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Mental health problems among adolescents left behind By their migrant parents in Romania

Dafinoiu, Alina

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MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS LEFT BEHIND BY THEIR MIGRANT PARENTS IN ROMANIA

By

Alina Dafinoiu, BSc, MSc

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Department of Psychology

University of Roehampton

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ABSTRACT

Since the fall of the communist regime in Romania in 1989 and the lifting of the Schengen visa restrictions, an increasing number of Romanians have been migrating to other European countries in search of economic opportunities. It is estimated that 15% of the Romanian population has left the country. While parental migration brings significant opportunities to the society and the family in terms of the remittances that the immigrants sent home, little is known about its impact upon the lives of the adolescents who are left behind (LBA) in Romania. Reports from various charities show LBAs who have mental health problems receive "help" mostly from adults without or with little training in the provision of mental health services. However, empirical evidence to support these reports is absent. The overall objective of this thesis is to investigate living condition and mental health status among adolescents in Romania and adults' mental health literacy. To achieve these objectives, four studies were conducted: **Study 1** examined the prevalence and correlates of mental health problems among adolescents who attended 17 public schools (N=1763) in and around Iasi, Romania. **Study 2** (N= 887) focused on the characteristics of LBAs in terms of their living arrangement, contact with their migrant parents, and their mental health status. **Study 3** compared the prevalence and stability of mental health problems of LBAs and adolescents from non-migrant families who participated in study 1 and who were followed up at an average of 12 months after the first assessment (N=972). Participants in studies 1 to 3 completed a set of questionnaires to measure mental health problems, social support, and parenting styles. **Study 4** examined mental health literacy among adults (N=250) who work with adolescents; these adults were recruited from public institutions in Iasi; they were administered a questionnaire describing five

vignettes of young people with common mental health problems. Results showed that almost 20% of the adolescents have mental health problems as measured with the Strength and Difficulties Questionnaire (SDQ with emotional problems being the most common). About 15.8% of the participants had migrant parents and half had a migrant mother. No significant differences were found in the prevalence and stability of mental health problems between the two groups of adolescents (i.e., adolescents with migrant parent(s) and adolescents with non-migrant parents). Mental health literacy was low among adults who work with adolescents. These findings are discussed in terms of their clinical and policy implications.

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Conference papers on the present studies

Dafinoiu, A., Georgiou, G., & Essau, C.A. (July 2014). Mental Health Literacy in Romania. *9th International Conference on Child and Adolescent Psychopathology.* Roehampton University, UK. July 2014.

Dafinoiu, **A., Georgiou, G., & Essau, C.A.** (July 2014). Psychological wellbeing of "Home Alone" Children in Romania. *9th International Conference on Child and Adolescent Psychopathology.* Roehampton University, UK. July 2014.

Dafinoiu, A., Georgiou, G., & Essau, C.A. (November 2014). Psychological wellbeing of "Home Alone" Children in Romania. International Symposium INTOVIAN, Protecting Infant and Toddlers from Domestic Violence. Lisbon, Portugal. November, 2014.

Dafinoiu, A., Georgiou, G., & Essau, C.A. (July 2015). Living Arrangement of "Home Alone" Children in Romania: Does it have any Impact on their Psychological Wellbeing? 10th International Conference on Child and Adolescent Psychopathology, Roehampton University, London.

Dafinoiu, A., Georgiou, G., & Essau, C.A. (November 2015). Prevalence of mental health problems among "Home Alone" children in Romania. European Symposium on Adolescent Research & Research Method Workshop, Roehampton University, London. November 2015.

Dafinoiu, A., Georgiou, G., & Essau, C.A. (November 2015). Psychological wellbeing of "Home Alone" Children in Romania. First International Congress of Clinical Psychology with Children and Adolescents. Madrid, Spain.

Dafinoiu, A., Georgiou, G., & Essau, C.A. (July 2016). Prevalence of mental health problems among "Home Alone" children in Romania. 11th International Conference on Child and Adolescent Psychopathology, Roehampton University, London.

ABBREVIATIONS

ADHD	Attention deficit hyperactivity disorder
ANOVA	Analysis of variance
APA	American Psychiatric Association
CBT	Cognitive behavioural therapy
CJRAE	Centrul Judeţean de Resurse şi Asistenţă Educaţională
DASS	Depression Anxiety Stress Scales
DGASPC	Direcţia Generală de Asistenţă Socială şi Protecţia Copilului
DSM	The Diagnostic and Statistical Manual of Mental Disorders
EU	European Union
GAD	General anxiety disorder
GCSE	General Certificate of Secondary Education
GDP	Gross domestic product
GP	General practitioner
HAC	Home Alone Children
ICD	International Statistical Classification of Diseases and Related Health Problems
IOM	International Organization of Migration
KS	Kolmogorov Smirnov test
LBA	Left Behind Adolescents
LBC	Left Behind Children
MANOVA	Multivariate analysis of variance
MDD	Major Depressive Disorder
MHL	Mental Health Literacy
NCES	National Center for Education Statistics
NGO	Non-governmental organization
NICE	National Institute for Health and Care Excellence
ODD	Oppositional Defiant Disorder
PBI	Parental Bonding Instrument
PSS	Perceived Social Support
RUSH	Roehampton University-Sacred Heart
SAD	Separation Anxiety Disorder
SAHA	Social and Health Assessment

SDQ	Strengths and Difficulties Questionnaire
SENCO	Special Educational Needs Coordinator
SPP	Social Support
SPSS	Statistical Package for the Social Sciences
SSA	Social Support Appraisals Scale:
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
UK	United Kingdom
VIF	Variance inflation factor
WHO	World Health Organisation

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CHAPTER 1: INTRODUCTION

'Migration is generally guided by the quest for a better life which `oftentimes means a better job' (CURS, 2005 as cited in Alexandru, 2012, p. 113)

1.1. Context of the Thesis

Many countries have experienced economic and financial crises, which made international migration be one of the most common and debated topic (Ciupureanu, 2014). Therefore, migration is one of the most common phenomenon worldwide, as well as the number of children and adolescents (hereafter this phenomenon is called "left behind adolescents; LBAs) who are left behind by their migrant parents (Cappelloni, 2011). Consequently, as the number of parental migrants increases, so does the number of LBAs. In some countries the number of children who are left behind by their migrant parents is so high that it represents a significant percentage of the total youth population (Cappelloni, 2011). For example, in the Republic of Moldova, 31% of children have at least one parent working abroad, and in the Philippines around 27% of children are left behind by their migrant parent(s). Most of these LBAs are in the care of their relatives, sometimes in the care of their friends or even by themselves for a certain time.

Previous studies have focused mostly on the positive side of migration, which is the remittance, the money sent back to their left behind families. For many developing countries (such as: Moldova, Tadjikistan, Honduras, Kyrgyzstan), remittances have made a significant contribution to the country's Gross domestic

product (GDP), as well as to the private sector, foreign investment and development aid (Cappelloni, 2011). One of the countries that had benefitted from economic migration is Romania. According to Ciupureanu (2014), Romania's GDP per capita (i.e. measured in US dollars) has increased from 38% (i.e. before joining the EU) to 54 % (seven years later). However, migration has a negative effect on those who are left behind, especially children and adolescents where parental migration has been associated with mental health problems, suicide, and academic underachievement.

Adolescence is the transition period from childhood to adulthood, which is associated with significant changes on the physical, emotional and cognitive levels (Crone & Dahl, 2012). These changes are associated with intense emotionswhich have been reported to be responsible for suicidal behaviour and psychopathology. As reported by numerous authors (e.g., Kessler et al, 2005), most mental disorders (e.g., anxiety and depression) emerge during adolescence. Mental disorders that have an onset during adolescence tend to predict a wide range of mental disorders and psychosocial impairment in various life domains in adulthood (Essau, Lewinsohn, Olaya, & Seeley, 2014).

1.2. The present research program

The present research program consists of four studies:

- The first study was designed to examine the prevalence, correlates, and predictors of mental health problems among adolescents. A total of 1764 participants were randomly recruited from 17 schools from the city of Iasi and the surrounding areas.

- The second study examined a subset of adolescents (from study 1) whose parent(s) work abroad; for simplicity, this group of adolescents (N=887) are called the “left behind adolescents” (LBAs). The main aim was to examine LBA’s living arrangements, contact with their migrant parents, and frequency of receiving remittances from their migrant parent. Another aim was to examine the prevalence and correlates of mental health problems among LBAs.

- The third study compared the prevalence and stability of mental health problems among LBAs as well as among adolescents from non-migrant families. Participants of study 3 who took part in Study 1, were re-examined at a time interval of approximately 12 months (N=972).

- The fourth study examined the level of mental health literacy of professionals and non-professionals in relation to youth mental health. A total of 250 participants, consisting of various professional groups and non-professionals who work with children and adolescents participated in this study.

CHAPTER 2: ROMANIAN'S LABOUR MIGRATION

2.1.Labour migration: An overview

International labour migration is a much-debated topic due to its complex and controversial features (Incaltarau, 2007; 2013). Before the 1990s, international labour migration was seen as neither positive nor negative, however, after World War II, it has been seen as something positive because of the economic capital acquired through remittances (Abreu, 2012; Castles, 2008; de Haas, 2012, 2007; Taylor, 1999). In this respect, migration was directly related to economic growth, as was the case in the USA and in many Western European countries.

The first wave of migration took place in the 19th century (i.e., between1820 to 1920), when a high number of Europeans (around 55 million) decided to migrate to the United States, Australia and Asia (Hatton & Wiliamson, 1998). The second wave took place between 1950s and 1960s, with a high number of Europeans migrating from Southern Europe (i.e. Spain, Italy, Portugal, Greece, Yugoslavia and Turkey) to central and northern Europe (i.e. West Germany, France and Switzerland), (Salt & Clout, 1976). Since the 1970s the economic gaps got worse due to the brain drain movement. As a result, it was the developed countries that lacked highly skilled and dynamic people benefited by those who chose to migrate abroad. The situation changed in the 1990s, when the migrants decided to return back to their countries of origin and started to share the experience they gained (i.e., the so-called "brain gain movement") (Incaltarau, 2007; 2013). In this respect, migration is said to have a "U" shape as the

phenomenon has changed its status from emigration into immigration (de Haas, 2010; Martin & Taylor, 1996; Skeldon, 1997).

In a theoretical model by De Haas (2010) the process of migration is considered to be based on aspirations and capabilities. Migration capabilities refer to the social and material capital aspects of individuals who are capable of "moving" so that they can migrate to other countries. This model also considers the concept of development which refers to the process in which the person is able to migrate across large distances in order to gain their freedom and live the life they have dreamed about. People's life aspirations tend to increase as a consequence of human development. Moreover, when the countries or different regions are developing, they tend to attract more and more immigrants from poor areas. At a certain point the relationship between immigration and development is expected to be linear.

2.2. An overview of migration in other Eastern European countries

After the Soviet-era breakdown, in the Republic of Moldova, migration that took place between 1990 and 2000, was influenced by political and ethnical reasons. In 2005, Moldovan National Demographic and Healthy Survey argued that economic labour was the main cause for Moldavians migrating abroad, 83 % were females and 91 % males. Other reasons that led Moldavians to migrate were connected to their wish to improve their living standards by building a house or buying an apartment (UNICEF, 2008). Men chose low and medium skilled jobs in Russian labour markets, while women chose to work in domestic services in Italy (Vanore, Mazzucato, & Siegel, 2015).

Simultaneous with the opening of labour markets in European Countries was the beginning of the Polish labour migration. This migration is attributed principally to the economic needs of Polish people. Until 2004 most Polish migrants chose mainly to migrate to Germany, followed by the United Kingdom, Ireland and Iceland. It was estimated that there were eight hundred thousand Polish emigrants in 2006 (Roman, Roman & Marin, 2010). However, though there was an increase in migration, Polish migration to EU countries was temporary (Roman & Marin, 2010).

Bulgarian migration was stable after its accession to EU in 2007 and kept a steady pace in 2008 and 2009. Most Bulgarian migrants from Spain and the United Kingdom began to return to their country of origin, as they were employed in low skilled jobs abroad, such as in agriculture, in factories or construction. The Bulgarian government also started to develop policies to attract migrants back to their country (Roman & Marin, 2010).

2.3. The fall of communism in Romania

Romania's history shows that it was a country of emigration rather than immigration. Before the communist regime, Romania was a multicultural country with a large number of ethnic minorities (e.g., Hungarians, Jews, Germans, Greeks) who considered Romania as a safe place to live because of common historical ties (Baldwin-Edwards, 2007; Suciu, 2010). Furthermore, during the communist era between 1947 and 1989, Romanian citizens were unable to leave the country without "Miliția" (police's) approval (Suciu 2010, p. 3). International travel was limited and restricted at that point, leading to a large number of people from the cultural and

political elite facing forced migration. Labour migration was related to a larger extent to the post-revolutionary period (Andrioni, 2011). That is, during the 1990's the lack of governmental control in several fields (e.g., factories) led to major changes in mining and metallurgy, which made people feel safe by having good living conditions and working places.

Romania is one of the largest countries in Eastern Europe with a total population of 22 million people. Despite being accepted in European Union (EU) since 2007, Romania still faces economic difficulties (Robila, 2010). Therefore, when Romania was accepted in the EU, several western European countries had the fear that mass migration would start, even though Romania had a "relatively short history of migration" (i.e., Uccellini, 2010, p.71). Moreover, when visas for the Schengen Area were no longer required, the number of migrants increased substantially with many Romanians chose countries such as Italy and Spain as their destination, this resulting in network migration (Sandu, 2006). The number of migrant continued to increase despite a surge in the Romanian labour market because many Romanians were attracted to well-paid jobs abroad (Incaltarau, 2007; 2013).

2.4. Migration wave after the communist regime collapsed

According to Incaltarau (2007; 2013), Romania has experienced two waves of migration. *The first stage* of migration started between 1990 and 2002, immediately after the communist regime collapsed. Following the implementation of the new economic reform by the new political regim, Romania experienced its first economic crisis (Scrieciu & Winker, 2002). However, the National Romanian Bank tried to

reduce the inflation between 1995 and 1996, which was considered to be a good period for the country. After 1996, previously economic reforms that included privatization led to high unemployment rates among Romanians. Even though the government supported the new reforms, the private sector did not have the appropriate environment to develop economically. Therefore, as the incomes were reduced due to high inflation, people started to migrate to the rural areas, as the living costs were cheaper compared to the urban areas. This led to a higher rate of employment in the agricultural sector compared to industrial or commercial sectors. At the same time, international migration started to become a second choice for Romanian citizens due to low incomes and living conditions (Carothers, 1997; Neef, 2002).

The second wave of migration started in 2000. After 2002, the private sector started to experience an international investment flow. When the Schengen Visas were no longer required, the Romanians started to migrate abroad with Italy and Spain being their favourite destination countries (Sandu, 2006). Because the wages in the destination countries were higher and getting a job for low skilled workers was more accessible than in Romania, more Romanians were attracted to work across the borders (Cindrea, 2007; Elias, 2007). This situation has led to a new employment problem because the firms in Romania have difficulties in recruiting people.

Unlike Incaltarau (2007; 2013), several authors such as Suciu (2010), Balcanu (2008) and Sandu (2006) claimed that Romania experienced three migration waves, which took place between 1990 and 2006:

- The first phase started in the early 1990s until 1995 and the main destinations were Israel, Turkey, Hungary and Germany. Moreover, between 1990 and 1993

there was a mass emigration of people with German and Hungarian backgrounds. In 1992, a high number of Romanians applied for political asylum in the West. From 1994 to 1996, the number of migrants bound for Western Europe decreased. However, the emigration rate at this time was 3% and this may be explained by the fact that the Romanians were seeking just seasonal or illegal work (Baldwin-Edwards, 2007; Traser 2008).

- The second phase started between 1996 and 2001, with Italy being the preferable destination for labour migration. According to Baldwin-Edwards (2007), the number of migrants increased to 7%, as more Romanians were looking for permanent migration to USA and Canada, rather than obtaining work permits for European countries. This was supported by Traser (2008) who argued that most of the migrants received assistance before their departure for abroad.

- The third phase began in 2002 when emigration rates increased sharply, with destinations of choice being Italy (50%) and Spain (25%). Labour migration focused mainly on these two countries because they are Latin-language countries which make it easier to get acculturated and that their languages were much easier to understand (Baldwin-Edwards, 2007; Traser, 2008).

2.5. Consequences of the fall of the communist regime

The main factors which led Romanians to migrate to other developed countries in Europe included lack of jobs, high monthly expenses and the industrial and economic restructuring (Alexandru, 2011; Cruceru, 2010; Gheaus, 2011). Vasile

(2014) similarly argued that the main reason for Romanians migrating abroad was due to economic reasons. Therefore, positing people in their country of origin (i.e Romania) would be paid less than their host country. Nevertheless, Harm (cited in Vasile, 2014) added that even though wages in Romania are lower than in the host countries, Romanian workers are usually paid much lower than the native/home workers. Thus, the decision of the future migrants is based on the level of advantages and disadvantages, and the gaps they might experience with the future job quality and employment opportunity (i.e., poor work conditions, possible xenophobic behavior and discrimination towards the migrant person).

Other factors which are responsible for Romanians to leave their country include:

- A lack of social and professional perspective or development (Miftode, 2006; Roman & Dumitru, 2010);
- Romanian business, mostly small businesses, is considered to be corrupt (Bleahu, 2004; Roman & Dumitru, 2010);
- Low salaries (wages) and insufficient income (Andrioni, 2011; Roman & Dumitru, 2010);
- European countries valuing highly skilled professional jobs (Andrioni, 2011);
- Insecure social and economic future for many families (Andrioni, 2011).

2.6. Different types of migration

2.6.1. Labour migration

In 2001, after the visa regulations were relaxed in many European countries, approximately two million Romanians were estimated to have migrated to Western countries (Andrioni, 2011). However, the number of migrants who left the country, according to the statistical service of Romania, was hardly the reflection of the real extent of this phenomenon (Baldwin-Edwards, 2007).

The Romanian temporary migration was considered to be an economic migration (i.e., labour migration). The total labour force (57.9%) in Romania was lower compared with the European average (62.5%) and this was considered to be another cause for forced migration. According to the 2011 Census (cited in Vasile, 2014), the temporary migration was estimated around 5.53% of the total population. Even though the number of migrants was not consistent over the years, Italy had a high percentage of migrants (i.e. 37%), and is considered the favourite country for migration. The United States was the second country of destination for Romanian migrants (11.28%), followed by Hungary and Canada (11.28%, 9.35% respectively).

2.6.2. Network migration

Network migration has been described as “a vascular system” with a developmental cycle that includes internal and external changes within the relationships which lead to the lifecycle of the networks (Kearney, 1986, p. 353). This

process involves informal networks that support the new migrants with finance, transportation, accommodation and even jobs (Balcanu, 2008). For Romania, these migration networks have three important kinds of flows: information flow, money flow and people flow (Bleahu, 2004). The information flow entailed informing new Romanian migrants about strategies before going abroad. The money flow had the role of supporting the new migrants economically. The people flow involved giving advice and assuring the new migrant comers about the living conditions and introducing them to the black labour market as well.

Many networking relationships were formed between 1990 and 2002 (Bleahu, 2004). The main destination countries for network migration were Italy and Spain. Network migration was pioneered by a 25 year-old man, who in 1994 brought approximately 38 of his family and friends as migrants to Spain (Balcanu, 2008).

2.7. Summary

This chapter gives an overview of labour migration in Romania. Following the collapsed of the communist regime, the accession of Romania to the European Union and the lifting of the Schengen visa restriction, the number of Romanians who work overseas have increased substantially in recent years. Consequently, many children are being left behind in Romania. The impact of parental migration on the psychological wellbeing of the children who are being left behind (for simplicity, they will be called "left behind adolescents" [LBAs] in Romania remain unknown. Thus, the main aim of this research was to examine the living arrangement of LBAs and their mental health status. Another aim was to examine mental health literacy of adults in Romania who work with adolescents.

CHAPTER 3: PREVALENCE AND CORRELATES OF MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS

3.1. Overview

The term adolescence has its origins from the Latin verb *adolescere*, which means to grow up. The World Health Organization ([WHO], 2005) defined adolescence as the period in the individual's growth, characterized by psychological, physical and social changes, which occurs after the age of 10 and lasts up to 19. It was considered to be the period of rapid growth when the individual is experiencing major social, psychical and emotional changes, while making the transition from childhood to adulthood (Johnson & Wolke, 2013). According to UNICEF (2011), adolescence has been divided into two decades: the first one, between 10 to 14 years old, was called the early adolescent period, while the second one, between 15 to 19 years old, was considered the late adolescence.

The first decade (early adolescence) is the period which allows young people to develop themselves on a cognitive, emotional and sexual level. Moreover, they start to experience their psychological transformation in a safe and clear space, being supported either by a family adult member at home or in the school environment, without engaging themselves into adult roles. The second decade (late adolescence) is the period of risk-taking whereby they begin experimenting with the adult-type

behaviour (e.g., when the young individuals start to take decisions for themselves; UNICEF, 2011).

Adolescence is an important developmental stage because it is the period in which many mental disorders register their onset (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Ford, Goodman & Meltzer, 2003; Johnson & Wolke, 2013; Kessler et al., 2005).

3.2. Adolescent mental health problems

The World Health Organization defined health as an individual's state of well being which is represented by abilities to cope with daily life stress and can work effectively by contributing to community (WHO, 2005; 2001); it is also a state in which every individual realizes his or her own potential. As such, mental health is more than the absence of diagnosable mental health problems. Mental health problems are not a unitary construct and consequently several authors used empirical methods to classify dimensions or types of mental health problems (Quay, 1986). Categorical and dimensional approaches are two major approaches to taxonomy. The categorical approach is based on the presence or absence of symptom clusters such as those described in the Diagnostic Statistical Manual of Mental Disorders ([DSM-5], 2013) produced by the American Psychiatric Association, and the International Classification of Diseases ([ICD-11], 2018) produced by the World Health Organization (WHO). In its latest edition, The American Psychiatric Association (2013) defines a mental disorder as a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental

functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." (DSM-5, p. 20). However, the categorical approach of classifying adolescents is controversial because of the stigmatization effect of diagnostic labels.

The dimensional approach relies on the assessment of dimensions of function or dysfunction (Werry, 1985), and the items on the questionnaires are used to elicit the symptomatology of broad classes of disorder, or to elicit a general sense of distress. One of the most widely used instruments is the Strength and Difficulties Questionnaire (Goodman, 2009) which is widely used worldwide in both clinical and community settings. Currently, it has over 60 translations. The SDQ can be used to measure 25 attributes, some positive and other negative, which are divided into 5 scales (Emotional symptoms, Behavioural problems, Hyperactive-inattentive problems, Peer relationship problems and Prosocial behaviour).

Recent large-scale studies (e.g., Kessler et al., 2005) have reported that up to 30% of the adolescents in the general population met the diagnoses of any mental disorders. However, the prevalence of mental disorders tend to vary across studies/countries. For example, the prevalence rate in Siberian youth population has been reported to range between 15 to 20%, whereas in Norway 5% of children are reported to suffer from a mental illness. In a study in Iran, the prevalences of mental disorders among the 15 to 18 year olds were 16.6%. Of all these disorders, anxiety and depression are the most common (Gregory et al., 2007; Kessler, McGonagle, Swartz, Blazer, & Nelson 1993; Kessler et al., 2005). Because anxiety and depression are the most common mental health problems among adolescents, the focus of the present research is on these two mental health problems.

3.2.1. Definition of anxiety and depression

3.2.1.1. Definition of anxiety

Feelings of fear, worry or anxiety are normal reactions associated with stressful situations and are part of normal development and generally cease with time. However, if these symptoms become excessive and persist over time and cause a negative impact on the individual's daily life activities and functioning, they tend to develop as anxiety disorders. The Diagnostic Statistical Manual of Mental Disorders – fifth edition (DSM-5, American Psychiatric Association, [APA], 2013) differentiated between various types of anxiety disorders, including:

- Separation anxiety disorder (i.e. excessive, persistent concern about separation from major attachment figures).
- General anxiety disorder (i.e. an excessive worry, which has an impact on the person's daily activities).
- Social phobia (i.e. unrealistic fear of embarrassment, which makes the person feel and believe he/she is being constantly judged).
- Specific phobia (i.e. persistent unrealistic fear, triggered by a specific situation or object).
- Panic attack (i.e. intense fear or intense discomfort).

3.2.1.2. Definition of depression

Depressive disorders are described by the presence of specific depressive symptoms (e.g., depressed moods) which persist over time and which can cause disruption and functioning impairment (APA, 2013). In order to diagnose an adolescent with major depression he/she has to experience every day for two weeks, at least five symptoms out of nine symptoms (APA, 2013):

- depressed mood, which can been perceived as an irritable mood in children and adolescents;
- a considerably decrease in interests or pleasure in almost all activities;
- considerable weight loss or weight gain (in children it weight gains are less probable); increased or decreased appetite;
- hypersomnia and insomnia;
- psychomotor agitation;
- loss of energy or feeling fatigue;
- experience feelings of guilt or worthlessness;
- difficulties in concentrating or thinking;
- recurrent thoughts of death or suicidal ideation without having a specific plan.

While most of the criteria can be applied to children, adolescents and adults, some symptoms have been modified for children and adolescents. Specifically, irritability could be understood as a mood symptom together with depressed,

anhedonia (the loss of pleasure) and sad mood.

3.2.1.3. Definition of Dysthymia (APA, 2013)

Persistent depressive disorder, formerly known as dysthymic disorder (also known as dysthymia or chronic depression), was renamed in the DSM-5 (APA, 2013). Dysthymia is also known as chronic depression, because the primary feature of persistent depressive disorder is a depressed mood that doesn't go away over a long period of time.

The essential feature of persistent depressive disorder (dysthymia) is a depressed mood that occurs for most of the day, for more days than not, for at least 2 years (at least 1 year for children and adolescents).

This disorder represents a consolidation of The Diagnostic Statistical Manual of Mental Disorders – forth edition ([DSM-IV], 2000) defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.
2. Insomnia or hypersomnia.
3. Low energy or fatigue.
4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness.

Unlike in adults, in children and adolescents, the disturbance could last for 1 instead of 2 years. Some examples of symptoms of dysthymia are poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration and feelings of hopelessness.

3.3. Prevalence of mental health problems among adolescents using categorical approach

3.3.1. Anxiety disorders:

Recent epidemiological studies that used DSM or ICD criteria indicated that anxiety is the most common disorder among children and adolescents (Costello et al., 2003). It is estimated that between 2.5 to 25% of children or adolescents met the criteria for any anxiety disorders; the mean age of onset was around 11 years old (Breton et al., 1999; Costello et al., 2003; Kessler, 2005). Within the specific types of anxiety disorders, the rate for separation anxiety was the highest in childhood and decreased over time, whereas the prevalence for generalized anxiety disorder was found to increase with age (Costello et al., 2003).

Anxiety disorders tend to have an early onset during childhood or during early adolescence (Kessler et al., 1994; Wittchen, Essau & Krieg, 1991). Those with an early onset anxiety disorders are at a higher risk to develop other psychiatric disorders later on during adulthood and several of their life domains could be affected (Wittchen et al., 1991).

3.3.2. Depression:

The lifetime prevalence rates of depression among adolescents have been estimated to range from 18% to 32% (Kessler et al. 1993; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). Furthermore, adults who have depression tend to report the first episode of their depression to have occurred during adolescence (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984; Mitchell, McCauley, Burke, & Moss, 1988; Ryan et al., 1987). Individuals who experience depression during their adolescence period are at a higher risk to develop depression in their adulthood compared to those who have never experienced this disorder at an early stage (Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Weissman et al., 1999). A study by Birmaher, Ryan, Williamson, Brent, and Kaufman (1996) supported the idea that depression in adolescence has been associated with suicide.

Anxiety and depression cause significant distress by affecting many levels of an individual's life and by being associated with a high number of negative outcomes. For example, anxiety and depression were associated with low academic achievement (Birmaher et al., 2004) and problems in relationship with both family members and peers (Costello, Angold & Keller, 1999; Essau, Conradt & Petermann, 2000). When left untreated, mental disorders, which have an onset during adolescence, tend to have a chronic course and outcome (Essau, Lewinshon, Olaya & Seeley, 2014).

3.3.2.1 Prevalence of mental health problems using dimensional approach

Most studies that explored the prevalence of mental health problems using a dimensional approach have used Strength and Difficulties Questionnaire (SDQ). Studies that used SDQ have reported the prevalence of mental health problems to range from 4.8% to 26%. For example, in a study by Arman, Keypour, Maracy, and Attari (2012), 26% of adolescents reported abnormal SDQ total difficulties score. Similar results have been reported in a study conducted in Tehran, where the prevalence for abnormal score was reported to be 25.8%. Slightly lower results were reported in studies in Brazil (18.7%) and in Gaza (14.2%). Among adolescents in India, Barnerjee, Bhat and Chatterjee (2015) found the prevalence of abnormal SDQ total difficulties score was very high (42%). Within the SDQ, conduct problems were the most common problems with prevalence ranging from 13.6% in Ireland (Greally, Kelleher, Murphy & Cannon, 2009) to 34.7% (Mohammadi et al., 2014).

Tabel 3.1. *Prevalence of mental health problems among adolescents from different countries*

Study	**Year**	**Country**	**Instrument**	**Number of participants**	**Age**	**Prevalence %**
Alavi et al.	2010	Tehran	SDQ	799	6-11	17.9%
Hashemi et al.	2012	Iran	SDQ	1150	6-12	19.3%
Arman	2012	Iran	SDQ	2000	6-18	26%
Elberling et al.	2010	Denmark	SDQ	3501	5-7	4.8%

SDQ= Strength and difficulties (Goodman, 1997)

3.3.2.2 Comorbidity between anxiety and depression

Anxiety and depression are not only common, they tend to co-occur among themselves with other mental disorders. As reported in several studies, between 25% to 50% of the adolescents had anxiety and depression (Garber & Weersing, 2010; Merikangas & Avenvoli, 2002;). However, the comorbid rates vary across studies and disorders which could be attributed to various reasons, including: (a) types of anxiety disorders being examined (Avenevoli, Stolar, Li, Dierker & Merikangas, 2001; Bittner et al., 2007; Chaplin, Gillham & Seligman, 2009; Moffitt et al., 2007; Keenan, Feng, Hipwell, & Klostermann, 2009); (b) age of participants being examined.

Adolescents who have comorbid anxiety and depression have a more negative outcome of their disorders, compared to those with only either anxiety or depression (Garber & Weersing, 2010). That is, they tend to have more negative impact on youth relationships, school achievements, by making them be at a higher risk to develop other disorders or to have suicidal ideation (Costello, 2003; Gould et al., 1998; Rohde, Lewinsohn & Seeley, 1994). Those with a comorbid anxiety and depression also have a higher risk of recurrence and a longer duration of their disorders, have an increase in suicidal attempts, a decreased response to treatment and a higher frequency in using mental health services compared to those without any comorbid disorders (Garber & Weersing, 2010; Lewinsohn et al., 1993).

3.4. Correlates of anxiety and depression among adolescents

A wide range of factors that place the adolescents at risk in developing mental health problems have been examined (e.g., Jessor, Donovan, & Costa, 1994)

In the present research, a selected list of factors were examined, including, namely, gender, age, parenting styles and social support.

3.4.1. Perceived social support

During adolescence, peers tend to become the most important source of help, followed by family (Väänänen, Marttunen, Helminen & Kaltiala-Heino, 2014). During childhood, families are considered the strongest and the most important source of support, followed by peers and, in some cases, by teachers (Ezzell, Swenson, & Brondino, 2000). Thus, even though the initial source of support comes from the family, as they grow older (i.e., during adolescence), peers start to play an important role in adolescents' life and it is their key source of support.

A study conducted by Väänänen and colleagues (2014), reported that low social support was a risk factor for adolescents' anxiety and depression (e.g., Väänänen et al., 2014). Some authors (Greca & Lopez, 1998)) suggested that having low social support could make adolescents feel insecure in certain social situations, which put them at risk in developing social phobia. Furthermore, it was hypothesized that receiving high social support from family, but lacking perceived support from friends might also lead to social phobia. La Greca and Lopez (1998) found that adolescents who experienced social anxiety had lower friends' support as well. Similar findings were reported by McDonald, Bowker, Rubin, Laursen, and Duchene (2010) in that less support from friends was associated with social anxiety.

Some studies have reported that low social support was associated with depression among adolescents, whereas other studies found that high social support had a "buffering effect against emergence of adolescent depression" (Väänänen et al., 2014, p. 1024). Adolescents with both low family and peer support were at a higher risk to experience depression either in middle or in late adolescence (Denny, Fleming, Clark, & Wall, 2004).

3.4.1.1. Perceived social support and depression

Numerous studies have reported that females received significantly more social support from friends or significant other, compared to males (Bettge et al., 2008). Furthermore, the association between social support and depression was stronger among girls than boys (Bettge et al., 2008). According to La Greca and Lopez (1998), lack of social support has a higher detrimental impact on girls compared to boys, by affecting their social functioning.

Väänänen and colleagues (2014) similarly reported that low social support was a risk factor for depression. Specifically, the findings showed that for both genders, low social support total score and low social support from significant others predicted depression at age 17. When analysing if there are any gender differences regarding the perceived social support, results indicated that girls received more peer support compared to boys. These findings are similar to results from previous studies, such as those by La Greca and Lopez (1998) and Katainen, Räikkönen, and Keltikangas-Järvinen (1999). Facio and Batistuta (2001) explained that these findings are due to girls' ability and nature of developing and emphasizing their relationships with friends;

specifically, girls tend to focus on the dyadic type of relation by helping them build stronger connections, whileas boys tend to focus on large groups of friends. However, in a study by Väänänen and colleagues (2014), there were no significant gender differences on significant other support.

3.4.1.2. Perceived social support and anxiety

Low support from significant other and low support from family have been reported to predict the development of anxiety disorders (Greca & Lopez, 1998). In a study byVäänänen et al. (2014) low support perceived from friends was found to be a predictor for social phobia. In order to understand these different results between Väänänen et al. (2014) study and the study conducted by La Greca and Lopez (1998), it should be mentioned that in the Väänänen et al.'s (2014) study the risk factors were analyzed separately for depression and social phobia. Moreover, they argued that when they analyzed the risk factors and their effects on these disorders, they took into account that depression (Bettge et al., 2008; Bittner et al., 2004; Hankin, 2009; McDonald, Bowker, Rubin, Laursen & Duchene, 2010) and social phobia (Wittchen, Stein, & Kessler, 1999; Väänänen et al., 2011) was associated with low social support. Furthermore, results from the same study found no association between low social support and comorbid social phobia and depression. Their result showed a significant association between social support and "pure" depression, however, no significant association was found between social support and social phobia (Väänänen et al., 2014).

The comorbidity between these disorders (i.e. social phobia and depression) is highly associated with social phobia risk factors, rather than with those risk factors related to depression. Another reason for these interesting findings was that when depression had a connection with social phobia, it develops differently from when it is on its own, as it was mentioned above.

Findings from the same study have shown that those adolescents who were reported to have both disorders, their scores for perceive social support was lower compared to the control group (i.e. who reported higher score for perceived social support). Moreover, both adolescents who were experiencing depression, reported to perceive lower support from their family compared to those who had social phobia. This could be argued, according to Väänänen et al. (2014), that those adolescents who are reported to experience social phobia, are more likely to seek support from their families, rather than those who experienced depression. Even though it was expected that the results would indicate that depressed adolescents would need more support than those who suffer from social phobia, the findings presented above showed exactly the contrary. According to the authors these varying results could be explained by the fact that those who suffer from depression are less likely to seek help from none any of those three sources mentioned previously, as they consider they are not liked or accepted by the others; by contrast, those who suffer from social phobia, would rely more on the support coming from outside in order to overcome their situation.

Previous studies have indicated that girls perceive more support than boys, having high scores for perceived friends and significant other support (Bettge et al., 2008; La Greca & Lopez, 1998; Väänänen et al., 2014).

3.4.2. Parental bonding for depression and anxiety

Before examining any association between parental bonding and adolescents' outcomes, it is important to understand the difference between parental care and parental control: parental care and parental control. Parental care refers to closeness, empathy, warmth and emotional aspects, that are specific features for some parents refers to those parents who are over- intrusive, over- controlling and treating their adolescents as if they were still infants, making them dependent on them all the time, by not allowing them to develop as independent individuals who should stand for themselves (Ngai, 2015).

To understand and to identify if parental bonding has an effect on depression and anxiety, socio-cultural differences should be taken into consideration, due to various "views of applicability of the Western based PBI factors of parental care and parental control" (Ngai, 2015, p.319). In support, Darling and Steinberg (1993) considered that in order to have a better understanding on how these factors affect adolescents' psychological status and development, it is highly important to take into account the cultural differences as well as their specific values. Therefore, in a study conducted by Chao (1994), the findings have shown that the parenting style for Asian families is authoritarian or even controlling in most Chinese families. Additionally, studies conducted on Chinese youth have found that parents are more restrictive compared to Western countries (Lin & Fu, as cited in Ngai, 2015). Moreover, the author argued that these features of parenting style are considered as positive among Chinese children and adolescents because they are associated with higher school achievement compared to European-American families, where the same parenting style is perceived as being detrimental for children's development. Furthermore, it could be

stated that parental control could be considered as having positive effects on adolescents' outcomes (Ngai, 2015).

In a study conducted by Pedersen (1994) in Norway, participants who reported high level of parental control (overprotection) and low scores for parental care were more likely to develop anxiety and depression. These findings were supported by a study, conducted in 2004, by Martin, Bergen, Roeger and Allison (as cited in Ngai, 2015), who also found that low levels of parental care and high levels of parental control were associated with some depression symptoms, such as suicidal ideation and thoughts and wish to harm themselves. Moreover, Canetti, Bachar, Galili-Weisstub, De Nour, and Shalev (1997) conducted a study on adolescents from the United States of America and reported that the association between low parental care and high level of parental control (overprotection) increase the risk to experience different types of psychiatric symptoms such as: depression and anxiety. Therefore, according to these studies, it could be concluded that PBI two dimensions, which are considered to be risk factors in adolescents' development, are associated with suicidal ideation and thoughts, depression, and anxiety. Indumathy and Ashwini (2017) supported these results with their findings that those adolescents who lacked parental care or reported parental overprotection were at a higher risk to be affected on the psychological level.

Ngai (2015) stated that most studies that focused on which PBI factors have an impact on adolescents' development have been conducted in Western countries. According to his study on Chinese adolescents from Hong Kong, findings have shown that low parental care and high parental control are associated with negative outcomes, such as bad thoughts regarding the future. Even though these results are not similar to

previous studies, the author has argued that Hong Kong is considered to be a Metropolitan area, and therefore the culture is more related to Western countries where the young population are more eager to become independent (Ngai, Cheung, To, Liu, & Song, 2013).

3.4.3. Parenting style

Adolescence is a developmental phase of wanting to become autonomous and independent (Frey, Ruchkin, Martin & Schwab-Stone, 2009). As a result of their moodiness and their cognitive, social and physiological changes, adolescence is often associated with conflict between adolescents and their parents (Arnett, 1999). Frey and colleagues (2009) stated that despite these changes mentioned above, parental care, warmth and support play an important role in adolescents' development, helping them cope with various life challenges. For example, a study conducted by O'Donell, Schwab-Stone and Muyeed (2002) among 2,600 adolescents, recruited from public schools, found that parental support was associated with multiple resilience outcomes among adolescents who experienced exposures to community violence, such as: conduct problems, depression, anxiety and substance use. According to Wallen and Ruben (1997), some parents may not understand or be aware of the violent context their children are exposed to, witness it or guess how big their distress can be. Therefore, the authors suggested that parent-child interaction and their relationship should be stronger, by offering support, stability, encouragement, advice in order to help their children cope in the right way, in case they experience community violence. In support to these suggestions, Frey and colleagues (2009) reported in their study that

parental control predicted low levels of violent activity and high scores for academic motivation.

Previous studies have focused on parent-child interaction and which outcomes are associated with this interaction that is characterize by support, supervision, involvement and parental warmth, help to prevent adolescents from develop in mental health problems (Stadler, Feifel, Rohrmann, Vermeriren, & Poustka, 2010).

3.4.4. Gender

Greally, Kelleher, Murphy and Cannon (2009) found that girls reported to have more SDQ total difficulties score (9.7%) compared to boys (7.6%). Girls reported to have more emotional problems compared to boys, whereas boys had higher scores for conduct problems (Greally et al., 2009). The main findings indicated that 8.7% of Irish adolescents reported to have an abnormal score for SDQ total difficulties score.

3.4.4.1. Gender differences in anxiety and depression

Anxiety: Results from previous studies have reported that girls had higher prevalence of anxiety symptoms and disorders compared to boys (Essau et al., 2000; 2014; Pine, Cohen, Gurley, Brook, & Ma, 1998); these differences are more present from age 12 to 15 (Duchesne & Ratelle, 2016). In a study conducted by Essau, Anastassiou-Hadjicharalambous and Munoz (2013), the results showed that girls reported to experience more anxiety symptoms than boys. These findings were supported by previous studies who reported that twice more girls than boys were more likely to experience an anxiety disorder by age 6 (Lewinsohn, Gottlib, Lewinsohn,

Seeley, & Allen, 1998). The reasons for this gender difference are not clear, though, Silberg, Rutter, Neale, and Eaves (2001) argued that these findings are due to genetic inheritance and therefore girls have a high predisposition to develop anxiety disorders. Other studies (e.g., Hankin, Mermelstein, & Roesch (2007)) stated that girls need interpersonal affiliation and if they lack it, then they are at a high risk to suffer from anxiety.

Depression: Epidemiological and clinical studies have consistently reported that girls are at a higher risk to develop depression than boys in adolescence (Garber, 2006). While some studies have indicated that prior to adolescence, both girls and boys experienced the same level of depression, other studies did not support this as their findings showed that girls reported to experience depression almost twice or three times more than boys in their early and middle adolescence. For example, a study by Essau at al. (2000) indicated that there were no gender differences before the age of 14, whereas girls experienced an increase in their level of depression after that age compared to boys.

Women not only have higher prevalence and incidence of depression but also their depression tends to be chronic with numerous relapses (Essau, Lewinsohn, Seeley, & Sasagawa, 2010). The reasons for the gender differences in depression is not clear, but hormonal changes, different ways to respond to stress, the level of stress, their skills regarding socializing as well as the interpersonal orientation differences have been suggested (Cyranowski, Frank, Young, & Shear, 2000; Essau et al., 2010, 2014; Hankin et al., 2007).

3.4.5. Age

In a study by Tehrani-Doost et al. (2008) girls aged between 13 to 18 years old were more likely to report emotional problems compared to boys. Another study showed that there was a significant association between age and hyperactivity, and that younger participants are more likely to experience this disorder compared to the older age group (Mohammdi, Mahmoudi-Gharaei, Tehrani-Doost, Shahrivar & Saadat, 2008). Furthermore, Arman, Keypour, Maracy, and Attari (2012) found that there was an association between age and peer problems for the younger age group, more likely for girls, whereas a decrease for the older age group was reported.

3.4.5.1 Anxiety

Findings on age differences in anxiety have been inconsistent. Some of the reasons could be due to differences in the use of instruments that were used to measure anxiety disorders. Another reason might be related to the type of anxiety disorders that were under investigation. For example, in a study by Essau et al. (2013), age was found to have an effect on separation anxiety disorder (SAD), social phobia and generalized anxiety disorder (GAD). The results revealed that the younger age group (12 to 14 years old) was more likely to experience SAD and social phobia disorder compared to the older age group (15 to 17 years old). However, for GAD the older age group reported higher scores than the other age group. Similar findings have been reported by Hale, Raaijmakers, Muris and Meeus, (2005) in that GAD scores were found to be higher in the older age group, even though it has its onset during childhood. It was argued that this disorder tends to increase in prevalence rates over time.

3.4.5.2 Depression

Several studies have reported a significant relationship between prevalence of depression and age (Essau et al., 2000; Kashani, Orvaschel, Rosenberg, & Reid, 1989), but not in others (Lewinsohn et al., 1993). The Isle of Wight Study reported a tenfold increase in depression when the 10-year-old children were reinterviewed four years later (Rutter, 1986). Other studies such as the Great Smoky Mountain study, has reported girls to show an increase of depression after the age of 12, although among boys there was a decrease after the age of 9 (Angold, Costello, & Erkanli, 1999).

3.5. Summary

This chapter begins by describing the definition of mental health and the two major approaches (i.e., categorical and dimensional approaches) in classifying mental health problems. The prevalence rates of mental health problems based on the categorical and dimensional approaches were then presented. Studies using the categorical approach indicated that up to 30% of the adolescents in the general population met the diagnosis of any mental disorders. Studies that used the dimensional approach similarly reported a high prevalence of mental health problems, with up to 42% of the adolescents could be categorised as having abnormal total difficulties score. The chapter ends by reviewing specific correlates of mental health problems, including, age, gender, parenting styles, and social support.

CHAPTER 4: PARENTAL MIGRATION AND ITS IMPACT ON THEIR CHILDREN

4.1. LIFE BEHIND ADOLESCENTS IN MOLDOVA AREA (FROM ROMANIA)

4.1.1. Migration as a wide spread phenomenon

Migration is defined as the relocation of parents in order to work abroad (Pottinger, as cited in Smeekens, Stroebe, & Abakoumkin, 2012). A transnational family is a widespread global phenomenon, where within the family there is at least one parent working abroad. Their children are left home alone with a caregiver, who can be the other parent, a relative or a non-kin person. According to the United Nations (2013), migration represents 3% of the world's population (Mazzucato, 2014). Transnational households are particularly common in many developing countries and as a result the number of children who are being left behind (LBA) has increased considerably in recent years (Cortes 2011; Mazzucato, 2014). In a study, conducted in 2005, by Bryant (as cited in Cortes, 2008), 2-3% of Thai and Indonesian children are estimated to have at least one parent working abroad. In Ecuador in 2005 the percentage of fathers and mothers who migrated was 40%, and 36%, respectively (UNDP, 2009). Moreover, a study by Save the Children (2006) indicated that there are around 1 million children with migrant mothers in Sri Lanka.

In the Republic of Moldova, approximately 17% of the children have at least one parent working abroad (Botezat & Pfeiffer, 2014). Furthermore, according to several authors, it was estimated that by 2010, about 22 % of Moldavian population would live abroad, half of them being women (Vanore, Mazzucato, & Siegel, 2015; Salah, 2008). UNICEF (2008) reported that 170,000 children were left home alone in the Republic of Moldova; a similar situation has been reported in Romania (Bilefsky, 2009).

4.1.2. The prevalence of left behind children and adolescents worldwide

Numerous studies have examined the number of children who are being left behind by their parents due to economic migration. Most of these studies have been conducted in China and in the Philippines. For example, in the Philippines, about 10% of the country's labour force chose to work overseas; this situation indicated that between 1.5 and 3 million children have parents who work abroad (Cortes, 2013; Mazzucato, 2014; Reyers, 2008). In China, Zhang (as cited in He, 2008) reported that in 2005, the number of left behind children in China has reached a peak of ten million; this figure is estimated to increase over the years. A more recent study (Hu, 2014) indicated that the number of left behind children in China had increased dramatically to 61.03 million. Another study in China, conducted by Wu in 2004 (as cited in He, 2008) reported a high percentage (47.4%) of children from middle and primary school that are left behind by their parents. Among these children, 31.5% have one parent working abroad, while 16.2% have both parents overseas. These numbers show that approximately half of the children from rural China are being left behind by their parent(s) (as cited in He, 2008).

While 56.4% of the children with migrant parent are left behind with their mothers or fathers, about have of the LBA are being left behind either with the grandparents (32.2%), relatives or parents' friends (4.1%), or with other families (0.9%) (He, 2008). In a study conducted by Chang, Dong, and MacPhail (2011), roughly 59 million children from the rural areas in China are being left behind with one parent, or with their relatives or grandparents.

4.1.3. Socio-demographic features of left behind children and adolescents in Romania

Various studies ad NGO reports have shown the increasing number of children who are affected by economic migration. Due to difference in methodological used, the number of children who are being left behind in Romania while their parent(s) work overseas differs across reports. Nevertheless these reports/studies gave a general impression on this common phenomenon (i.e., left behind children/adolescents). For example, in 2005 the UNICEF estimated in the Republic of Moldova, there were 32 % of home alone children, aged between 0 and 14 years old, who had parent(s) who worked abroad (Vanore et al., 2015). In 2006 in Romania, approximately 60,000 children were registered in the official data as having at least one of their parents working abroad (Botezat, 2014; Cortes, 2011; Toth, Munteanu, & Bleahu 2008; UNICEF, 2008); in 2007 there were 170,000 children with parents working abroad. According to National Child Rights Protection Authority, in the same year, the number of left behind children under 18 rose up to 82,464 (Social Alternative, 2010; Andrioni, 2011). A study conducted by Safta, Stan, Iurea, and Suditu (2014) reported that among

these children, 47,154 had one migrant parent, while 26,406 of them had both parents working abroad. In 2008, the number of left behind children increased dramatically to 92,000, which represents 2 % of the Romanian children (i.e. a total of 4.400.000, aged between 0 and 18 years old) (Botezat, 2014).

4.2.Positive and negative aspects of migration

4.2.1. Positive aspects of migration

Having parents who work abroad has been associated with a wide range of positive impact. The positive impact of parental migration is mostly related to the financial aspect of economic migration as parents are now in the better position to support their children such as their children's education (Botezat, 2014). Other studies support the idea that migration plays a positive role in school outcomes, health expenditure and household incomes (Gassmann, Siegel, Vanore, & Waidler, 2013; Macours & Vakis, 2010; Yang, 2008). Cortes (2011) argued that incomes from abroad have a positive effect on educational investments. UNICEF (2008) supported Cortes' (2011) and Yang's (2008) results by reporting that left behind children have access to more services (e.g., access to information technology through computers) compared to their peers who work in Romania. UNICEF report also indicated that left behind children were motivated to have higher grades "to show their appreciation for their parents' efforts" (UNICEF, 2008, p.13).

4.2.2. Negative aspects of migration

Numerous previous transnational family studies have focused on the negative impact of parental migration upon children's psychological wellbeing (Mazzucato, 2014). According to Levitt (as cited in Dreby, 2007, p.1051), these left behind children "pay the emotional price of separation from parents over the long run". Parrenas (2005) similarly who found Mexican children to feel abandoned due to parental migration; these children develop certain types of behaviour such as refusing to talk to their parents or ignoring their authority. Another study reported that Filipino children who are left behind suffer from loneliness especially when the migrant parent is their mother (Mazucato, 2014). A study conducted in China, on the other hand, similarly reported that children are at a high risk of poor mental health when they are left behind with their fathers (Wen & Lin, 2012). These children are more likely to experience severe loneliness and emotional distress when they are being taken care of by their grandparents (Vanore, 2015).

A study by Suarez-Orozco, Todorova, and Louie (2002) found that left behind children continue to experience the negative impact of parental separation (e.g., developing anxiety and depressive symptoms) even if they are reunited with their parents. Similarly, a study by Jones et al (as cited in Vanore et al., 2015) found that children who are left behind are more likely to experience emotional problems (e.g., depression and anxiety) than those from intact families. Another study by Smith, Lalonde, and Johnson (2004) identified that Caribbean children have developed behavioural problems and low self-esteem as a result of parental migration. Among Filipino migrant families (Parrenas's study, 2005), the incidence of psychological, social problems and delinquency are high among left behind children, especially when the migrant parent is their mother. In all the studies presented above, parental absence,

age of children left behind at separation and the caregivers are the factors that strongly influence the development of behavioural problems (Vanore et al., 2015).

Romanian children with migrant parents have been reported to frequently suffer from mental or physical illness, especially those from rural areas (Botezat, 2014); parental migration was also found to be associated with poor outcomes on health, school achievement and wellbeing (Fomby & Cherlin, 2007, as cited in Botezat, 2014; McLanahan & Sandefur, 1994; Page & Stevens, 2004). Moreover, Luca, Gulei and Azoitei (2007) identified through interviews that these children had to deal with too many tasks (e.g., taking care of their siblings), and that they tend to develop an aggressive and delinquent behaviour or starting to have feelings of abandonment, anxiety, sadness and depressive moods. Many of these children are at high risk of dropping out of school.

Cortes (2011) presented a study carried out by Manila's Scalabrini Migration Center who found that children with migrant parents had lower school achievements than their peers from intact families; these children were also more likely to express anger and apathy. Another study by UNICEF (2008) reported that children from intact families are physically healthier (87%) compared to those from migrant families (69%). It was found that these children are at a high risk of dropping out of school, substance use and precocious sexual relationships. Most of these left behind children described themselves as being isolated, sad, lonely and deprived of any kind of support (UNICEF, 2008). Among 2000 Chinese left behind children, 56 % of them had lower scores in school achievement; these Chinese children also reported feelings of helplessness, loneliness and weakness due to parental migration (He, 2008). In support,

Li (2004) noticed that left behind children are more likely to experience emotion problems due to lack of parental support. Chang et al. (2011) similarly found home alone children to report experiencing higher level of psychological problems since their parents work abroad compared to their peers from non-migrant families.

Additionally, research has suggested that the absence of an adult within the household has a negative effect on children's education due to labor pressure (e.g., they have to take care of the house and their siblings), lack of emotional support and supervision (Hu, 2012). Hu (2014) argued that parental separation causes family dysfunction and has negative impact upon children's quality of life and their psychological well-being. Indeed, numerous studies have shown left behind children to have a higher risk of developing mental health problems (e.g., anxiety, depression, loneliness, frustration, vulnerability, negative self-perception) compared to those from non-migrant families (Fabian & Domokos, 2008; Social Alternative, 2010; Safta et al., 2014).

In a study by Wen and Lin (2012), left behind children are reported to have negative psychological outcomes and their socializing skills and psychological traits mediated the relationship between parental migration and a child's well-being. Their results also showed that left behind children had lower school engagement and poorer health. Other researchers (Fan, Su, Gill, & Birmaher, 2010) indicated that left behind children in China reported more behavioral and emotional problems than pro-social behavior. These left behind children are at a high risk of developing behavioral and emotional problems if they are left home alone at an early stage because they lack their parental support and presence over an extended period of time. There were other

factors which influenced these results such as the type of caregiver, either she/he was too young or she/he was a non-relative who might have poor education and a low socio-economic status and thus unable to care for all the needs of the child. According to Mazzucato (2014), previous studies had focused on the parent who is migrating; however, children who are left behind by their mothers have been found to suffer more.

4.3. *Adolescents from non-migrant families*

Family characteristics such as family structure and social status are among the most important factors in determining children's mental health status (Acock & Kiecolt, 1989). As stated by Schneider and Owens (2006), the family structure can constrain economic support and social resources, which in turn often determine the amount of time parents spend with their children, including their involvement in their children's education. These disadvantages are due to different income, lack of time and not so many commitments regarding a child's well-being (Amato, 2001). These results are more common in the families with stepparents. As argued by Amato and Keith (1991) children coming from two-parent families should benefit from their parents' time and economic support, whereas children from a one-parent family or having stepparents lack all these resources (i.e., parent's time and economic support). In other words, parental involvement in their children's life is among one of the ways in which parents could make a positive influence their children's social, educational and psychological outcomes (Astone & McLanahan, 1991). In line with this argument, a study conducted by the National Center for Education Statistics (NCES), showed that children from traditional families (i.e. intact families) are more likely to have one of

their parents who is more involved in their life activities (e.g., who is getting involved in their school activities), compared to those who have a single parent or who have stepparents (Bane & Ellwood, 1983). Bethke and Sandefur (1998) concluded that those children who benefit from their parent's support and communicate with them frequently are more likely to have high school achievement and a good mental health status.

4.4. Summary

Although left behind children is considered to be a wide spread phenomenon in Romania and in other Eastern European countries, previous studies have mainly focused on reporting the situation of children with migrant parent(s) from Asian, Caribbean and Latin America countries (Popa, 2012). The literature review showed that the number of children/adolescents who are being left behind by their parents (LBAs) due to economic migration has shown a dramatic increase in recent years in Romania. The impact of parental migration among left behind adolescents (LBAs) is inconsistent. Some studies have shown a positive impact, while other studies have shown parental migration to have a negative impact on LBAs' mental health. However, most of these studies were conducted in China and in the Philippines. While informative, these findings may not be generalized to left behind children in Romania due to cultural differences.

CHAPTER 5: METHODOLOGY

5.1. Overview

This chapter outlines the methodology used in the first three studies. The research designs and the rationale for selecting these are discussed. Details of instruments and data collection procedures including ethical considerations throughout this research are described.

Research design

This thesis adopts a quantitative approach, using both cross-sectional and longitudinal survey research and a quasi-experimental design. Table 5.1. summaries the research methods used throughout this thesis.

Table 5.1.Summary of Research Methods Employed

Study	Design	Data collection method
Study 1: Chapter 6	Cross-sectional	Survey
Study 2: Chapter 7	Cross-sectional	Survey
Study 3: Chapter 8	Longitudinal	Survey
Study 4: Chapter 9	Cross-sectional	Cross-sectional Survey Survey

Survey research was selected for the first three studies in this thesis because of the large number of variables to be examined which makes this the most practical methodology. Studies 1, 2 and 4 adopted a cross-sectional design to explore the relationships between a large number of variables. Building on these first studies, a longitudinal design was adopted in Study 3 to examine stability of mental health problems over time.

5.2. Participants used in the Thesis

Study 1 (see chapter 6, page 64): The aim of Study 1 was to examine the prevalence and correlates of mental health problems among adolescents in Romania. A total of 1764 participants were randomly recruited from 17 schools in and near the city Iasi.

Study 2 (see chapter 7, page 92): The aim of Study 2 was to examine the living arrangement of adolescents who have been left behind by their migrant parents (LBAs); another aim was to investigate their mental health status. Participants for this study included 889 LBAs.

Study 3 (see chapter 8, page 111): The aim of Study 3 was to compare mental health problems of adolescents from parental migrant (LBAs) and non-parental migrant families. Another aim was to compare the stability of mental health problems among these two groups of adolescents over a period of 12 months.

Study 4 (see chapter 9, page 127) examined mental health literacy among adults who work with young people in Romania. A total of 250 adults participated in this study.

5.3. Materials

5.3.1 Instruments used for Study 1, Study 2 and Study 3

Participants who took part in Study 1 (Chapter 6), Study 2 (Chapter 7) and Study 3 (Chapter 8) completed a set of the same questionnaires: The Strengths and Difficulties Questionnaire (SDQ), Child and Adolescent Symptom Inventory 4R (Youth Inventory 4R), Perceived Social Support (PSS), Parental Bonding Instrument (PBI) and The Social and Health Assessment (SAHA). The instruments used in Study 4 are described in Chapter 9, Section 9.11. These questionnaires were chosen because

they are widely used in various countries and settings due to their very good reliability and validity (Essau, 2009; Essau et al., 2001).

All the questionnaires were translated into Romanian, apart from SDQ; the SDQ was downloaded from the SDQ website (www.sdqinfo.com). All the questionnaires were translated and adapted from English to Romanian according to guidelines that are widely accepted for the successful translation of instruments in cross-cultural research (Brislin, 1970).

5.3.1.1. The Strengths and Difficulties Questionnaire

The **Strengths and Difficulties Questionnaire** (SDQ; Goodman, 1997) (Appendix IX.3) was used to assess general difficulties and positive attributes in children and adolescents aged 11 to 17. Its 25 items are divided into 5 scales, which generate scores for: Hyperactivity (e.g., "I am restless, I cannot stay still for long"), Emotional Symptoms (e.g., "I worry a lot"), Conduct Problems (e.g., "I get very angry and often lose my temper"), Peer Problems (e.g., "I am usually on my own. I generally play alone or keep to myself") and Pro-social behavior (e.g., "I try to be nice to other people. I care about their feelings"). Each of the items is rated on a 3-point scale, ranging from "not true" (0) to "certainly true" (2). Five items are negatively scored, and the rest are positively scored.

The total difficulties score can be obtained by adding the items of the four problem scales (excluding the pro-social behaviour scale). For simplicity, in the present study, the subscales were grouped into internalizing (emotional symptoms and peer problems) and externalizing (conduct problems and hyperactivity-inattention). The scores for both Internalizing and Externalizing scores range from 0 to 20. Even

though SDQ subscales scores could be used as continuous variables, it is more convenient for this study to have categories scores.

Both the internal consistency and test–retest stability of the SDQ has been reported to be satisfactory (Goodman, 1997). The SDQ correlated significantly with other measures of child and adolescent psychopathology including the Youth Self-Report (Achenbach, 1991). The reliability of the SDQ was reported in previous studies as good, with Cronbach's α being around the value .73 (Goodman, 1999, 2001; Mellor, 2004; Mellor & Stokes, 2007). In the present study, the Cronbach's α for the total SDQ scores was .73. The low Cronbach's α for some of the SDQ subscales replicated previous studies (e.g., Essau et al., 2014).

5.3.1.2. Perceived Social Support Scales

The **Perceived Social Support Scales** (PSS, Zimet & Farley, 1988) (Appendix IX.4) was used to measure the extent to which the adolescents perceived their friends, family and a significant other as fulfilling their needs for support. Each of these groups has four items. Each item was rated on a 7-point rating scale, ranging from "very strongly disagree" (1) to "very strongly agree" (7). The scale has good internal reliability with a Cronbach's α .88 (for the total scale). For each subscale the values indicated a good internal consistency as well, with the Cronbach's α ranging from .85 (for family) to .91 (for significant other). In the present study, the Cronbach's α for the total PSS scores was .76. The Cronbach's α for each of the subscales was: .88 for family, .86 for friends, and .76 for significant other.

5.3.1.3. The Parental Bonding Instrument

The **Parental Bonding Instrument (**PBI, Parker, Tupling, & Brown, 1979) (Appendix IX.5) was used to assess perceived parental bonding. It contains 25 items that can be used to measure "care" and "overprotection". The first 12 items refer to "care" dimension (e.g., "Spoke to me in a warm and friendly voice") and 13 items are intended to assess "overprotection dimension" (e.g., "Did not want me to grow up") that subjects recall to have received from either mother or father. The items are scored on a 4-point Likert scale ranging from "very likely" (1) to "very unlikely" (4), indicating the degree of the subject's agreement with each statement. High scores on the care subscale indicate warm and affectionate parenting attitudes and the low scores indicate rejection and indifference.

The PBI is a widely used instrument for measuring parental bonding because of its reliability and validity (Ngai, 2015; Qadir, Stewart, Khan & Prince, 2005). The split-half reliability of the PBI was .88 for the care scale and .74 for the protection scale (Parker et al., 1979; Wilhelm & Parker, 1990). In the present study, the Cronbach's α for mother care scale was .86 and .70 for the mother protection scale; for father care the Cronbach's α was .73 and father protection .70.

5.3.1.4. The Social and Health Assessment

The **Social and Health Assessment** (SAHA, Schwab-Stone et al., 1995; 1999) (Appendix IX.1) was used to assess the adolescent's involvement in a wide range of antisocial behaviour (e.g., gun or knife crime) and the risk of getting involved in antisocial behaviour (e.g., alcohol or drug use, deviant peers). SAHA consists of 9 items to assess the *affiliation with delinquent peers.* The questions are related to of the number of the respondent's peers who have been involved in different types of risk-

taking or antisocial behaviour; the items are to be rated on a four-point scale (from “none of them " to “most of all”). For the present study, the following subscales were used: (a) school and community activities; (b) friends' delinquent behavior; (c) background information; (d) experiences some people had: (e) p*arent-adolescent interactions*. In the present study, the Cronbach’s α for the total SAHA scores was .78.

5.3.1.5. Child and Adolescent Symptom Inventory-4R

The **Child and Adolescent Symptom Inventory 4R** (Youth Inventory 4R) by Gadow and Sprafkin (2004) (Appendix IX.2) was used to assess symptoms of DSM-IV-R disorders, namely, Attention Deficit/Hyperactivity Disorder (ADHD), conduct, anxiety, depressive and substance use disorders. It contains 88 items which can be rated as follow: “0=never; 1=sometimes; 2=often; 3=very often”. The YI-4R can be scored to derive Symptom Count scores (diagnostic model) or Symptom Severity scores (dimensional model).

‘Symptom Count’ was used to measure the categorical model of mental health problems. The scores represent the total number of symptoms, which were used to represent specific symptom cut-off score. Even though all items for all categories are scored “0=never; 0=sometimes; 1=often; 1=very often”, some were recoded as: “0=never; 1=sometimes; 1=often; 1=very often” to derive to a symptom cut-off score. Based on these cut-off scores, it can be establish if the total scores per category would indicate if the adolescents have or do not havea mental disorder.

Symptom Severity score: To obtain the severity score, each item (scored "0= never; 1=sometimes; 2=often; 3=very often") is summed up for each category: attention-deficit/hyperactivity disorder, conduct disorder, anxiety disorder, or major depressive disorder. In the present study, the Cronbach's α for the total Symptom scores was .90. The Cronbach's α for each of the Symptom severity scales ranged between .89 and .91.

5.4. Summary

This chapter gives an overview of the research design. The set of questionnaires that was used in studies 1 – 3 were described in detailed. These questionnaires were chosen because of they were widely used in numerous countries world-wide, which enabled comparability across studies as well as because of their reliability and validity.

CHAPTER 6. PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG ROMANIAN ADOLESCENTS (STUDY 1)

6.1. Overview

The main objective of this chapter was to explore the overall prevalence and correlates of mental health problems among adolescents in Romania.

6.2. Introduction

As described in Chapter 3, several recent epidemiological studies have shown mental health problems to occur frequently among adolescents in the general population, with prevalence rates ranging from 10% to 32% (Essau & Ollendick 2013; Merikangas et al., 2010). Among all the mental disorders, anxiety and depression are the most common (Merikangas et al., 2010). Most mental disorders have an early onset; for example, anxiety disorders have been reported to have the first onset during childhood, and depression during adolescence (DuRant, Smith, Kreiter, & Krowchuk, 1999; Jessor et al., 1994). Epidemiology studies conducted in Australia, Canada, and the United States of America have also reported numerous factors that put the adolescents at risk to develop mental health problems. These factors include gender, age, social support, family factors. While informative, it is not known if these findings could be generalized to adolescents in Romania. To our knowledge, a large survey that explore the frequency of mental health problems in Romania is lacking. To make up

this gap, the main aim of this study was to examine the frequency of mental health problems among adolescents in the regions of Moldova.

6.3. Rationale, Aims, Research Questions and Hypothesis

The specific aim of this study was to address the following research questions:

1. What is the prevalence of mental health problems among adolescents in the general population in regions of Moldova?
2. Which are the most common mental health problems among the adolescents with such problems?
3. Are there any gender and age differences in mental health problems?
4. What are the predictors of mental health problems?

The following hypotheses were tested:

1) Based on the World Health Organization (WHO, 2001) the prevalence of mental health problems among adolescents in Moldova area were expected to range from 10% to 20%;

2) The most frequent mental health problems were anxiety and depression (Costello, Copeland, & Angold, 2011; Essau & Chang, 2009; Jonson & Wolke, 2013);

3) There were significant gender differences on mental health problems, with girls reporting higher scores for emotional problems compared to boys who will have

higher scores for behavioral problems (Essau et al., 2014; Hankin et al., 2007; Pine et al., 1998; Silberg et al., 2001). Moreover, there will be age differences in mental health problems with adolescents in the older than younger age groups scored higher for both emotional and behaviourial problems (Essau et al., 2014);

4) Based on numerous studies, socio-demographic (e.g., sex and age) and family factors, such as: Parenting styles (Luxton, 2007; O'Donell et al., 2002), Social support (Angold, Costello, Farmer, Burns, & Erkanli, 1999; Denny et al., 2004; Väänänen et al., 2014) and Parental bonding (Martin et al., 2004; Ngai, 2015; Pedersen, 1994), were expected to be significantly associated with and predicted mental health problems.

6.4. Methods

6.4.1. Participants

A total of 1764 adolescents took part in this study. Eight participants were excluded from analysis due to too many missing data on various questionnaires. Therefore, data of 1756 adolescents (880 were boys and 876 were girls) were used for the analyses in the present study. Participants' age ranged from 12 to 18 (Mean = 15.80, SD = 1.28). A total of 439 participants were LBAs and 441 were adolescents from intact families (Table 6.1). A majority of the participants live in the urban area.

Table 6.1: Demographics of adolescents in Study 1 (N=1756)

	Boys N (%) 880 (50.1)	Girls N (%) 876 (49.9)	Total N (%)
Type of group			
LBA	439 (49.9)	452 (51.6)	865 (49.2)
INTACT	441 (50.1)	424 (28.4)	892 (50.8)
Age (years)			
13-14	122 (13.9)	128 (14.6)	250 (14.2)
15-16	514 (58.4)	489 (55.8)	1003 (57.1)
17-18	244 (27.7)	259 (29.6)	503 (28.6)
Living arrangement			
Both parents at home	440 (50.0)	424 (48.4)	864 (49.2)
Mother abroad	193 (21.9)	229 (26.1)	422 (24.0)
Father abroad	172 (19. 5)	157 (17.9)	329 (18.7)
Both parents abroad	74 (8.4)	65 (7.4)	139 (7.9)
Current place of living			
Rural	222 (25.2)	229 (26.1)	52 (25.7)
Urban	658 (74.8)	647 (73.9)	1306 (74.3)

6.4.2. Procedure

All participants were recruited from 17 schools in and around Iasi in Romania. The age of the participants who were recruited from the Junior Schools (7th grade), ranged from 12 to 14 (from 12th grade), whereas those from High School (which represents the Upper of the Secondary Education and offers a four-year program for adolescents) were aged between 15 to 18. These age groups (12 – 18 years) were chosen because they are considered the most vulnerable age groups where most mental disorders have their age of onset (Merikangas et al., 2010). All these schools were from the city of Iasi in the North-East of Romania (in Moldova area) and areas around the city (i.e. the rural areas). List of schools were provided by the School Inspectorate.

Before the data collection, ethical approval from the University of Roehampton Ethics Board (Appendix I) and the permission from the Ministry of Education and

Culture were obtained (Appendix II). Permission from each head teacher (Appendix IV) and principal (Appendix V) was also obtained. All participants received a letter for their parents (Appendix VI) given by the head teacher, which informed them about the purpose of the present study. Only participants whose parents/care givers who signed the consent form could participate in the study (Appendix VI); the participants also signed their own consent form (Appendix VII). Therefore, prior to completing the questionnaires, only those who had these two consent forms signed were allowed to take part in the current study.

The researcher (AD) administered the questionnaires in a designated room in the school. Each participant completed the questionnaires independently and they could ask questions to the researcher any time. All questionnaires were anonymously coded (i.e. which was built from the initials, month of birth and the specific number: e.g., AD_03_01) which could link the baseline to a follow-up data. Each participant received a debrief form (Appendix VIII) at the end of the study. The researcher made sure that each participant knew he/she had the right to withdraw at any time.

6.4.3. Instruments

All participants completed a set of questionnaires as described in Chapter 5. In brief, the demographic questionnaire was used to measure the participant's gender, age, region of living (i.e. rural versus urban), living arrangements, family structure; those from migrant family, were asked about the frequency of communication with their parents, remittances rates.

Mental health problems were assessed using Strength and Difficulties Questionnaire (SDQ; Appendix IX.3) and Youth Inventory 4 R (Appendix IX.2).

Other questionnaires were used to measure antisocial behavior (SAHA (Appendix IX.1), Social Support (SSA; (Appendix IX.4), Parental Bonding (Appendix IX.5) and Parenting Styles (i.e. scales from SAHA, Appendix IX.1). A summary of all the measures used in this study is listed in Table 6.2 below.

Table 6.2: Measures used in this Chapter/Study 2

Instrument	What measures It	Number of items	Reference	Cronbach's α
Demographic Information	Socio-demographic Information		New	
Youth Inventory 4R	ADHD, Conduct problems, Oppositional defiant, Generalized anxiety, Specific phobia, Panic attack, Social phobia, Separation anxiety, Major depression, Dysthyma, Substance use	89	Gadow and Sprafkin (2004)	0.90
SDQ	Hyperactivity, Emotional symptoms, Conduct problems, Peer problems, Pro-social behaviour	25	Goodman, (1997)	0.73
PSS (perceived social support)	Family, friends and other significant support	12	Zimet and Farley, (1988)	0.76
PBI (parental bonding)	Mother care and protection, Father care and protection	25	Parker et al., (1979)	0.70-0.86 0.73- 0.70

Cut off points for SDQ subscales

Following the method used by Du et al. (2008), cut-off points to identify normal, borderline and abnormal findings were established by using the distribution of raw scores. Cut-offs for the total difficulties scores were those which allow us to obtain approximately 10% abnormal scores and 10% in the borderline range. Cut-offs for the five subscales were chosen to obtain slightly lower percentage of abnormal and borderline cases (85% normal scores and 15% in the subclinical and clinical ranges). This was done to avoid identifying an excessively large proportion of children within the subclinical and clinical range. Once the cut-off points were identified, we classified adolescents into three groups according to their raw scores in each subscale and in the total score: normal, borderline and abnormal cases.

6.4.4. Statistical Analysis

The IBM SPSS 22 software program was used to conduct the analyses. Prior to data analysis, data were screened for missing values, outliers and normality of distribution.

A Kolmogorov Smirnov (KS) test was implemented for checking the normality of data distribution. The KS test was significant for almost all variables and thus the assumption of normality of distribution for these variables could not be confirmed. However, as none of the variables are higher or lower ±3 (Stevens, 2002) and the sample size is large enough and provides a power analysis, a decision was made to use parametric tests.

a) In order to report the prevalence rates of mental health problems among adolescents, cut off points of Youth Inventory 4 R and SDQ were calculated.

b) Univariate and multivariate analysis were carried out in order to identify the age and gender differences with regard to mental health problems and to those several factors which have an impact on these illnesses. Therefore, before running any analysis the assumptions for MANOVA were taken into account.

c) Hierarchical multiple regressions were conducted in order to identify factors (family arrangements, social support, parental bonding and parenting styles) which predicted adolescents' mental health problems. In order to run hierarchical multiple regressions with 14 predictors and 33 outcomes, a decision was made to assess these mental health problems. Firstly, we identified the most common mental health disorders among adolescents as measured using Youth Inventory 4R. Only the most frequent ones were used as outcomes for further analysis (social phobia, dysthymia, major depression, ADHD, specific phobia and panic attack). On the SDQ, the two subscales (Internalizing and Externalizing behaviours) rather than the four separate scales were considered to be preferable, in a community sample (Goodman & Goodman, 2009).

6.4.4.1. Checking for assumptions of the tests used in Study 1 (Chapter 6)

Assumptions for MANOVA: In order to check the assumptions of *homogeneity of variance-covariance matrix,* Box's M test of Equality of Covariance Matrices and Levene's Test for each dependent variable were conducted. The results indicated that the Box's M Test of the equality of covariance matrix was found significant (Box's M Test = 202.83, p = .000), which indicated that the matrices were not the same and the observed covariance matrices of the dependent variables were equal across groups, and therefore, the assumption was violated. According to Tabachnick and Fidell (2007), these results indicated that large samples produce grater variances and covariances, which means that the probability values will be conservative and, therefore the significant findings can be trusted. These results on homogeneity of variance-covariance matrix showed that we should take the Pillai's Trace test in order to examine the analysis, since the Box's M Test was violated. Moreover, the Levene's Test of Equality of Error Variances for each dependent variable was checked. The results indicated that the Levene's Test was not significant for any dependent variables.

Assumptions of Hierarchical multiple regression: In this study, random selection was used while taking into account independence of observation. Durbin-Watson test was used in order to check the independence of errors. Stevens (2002) stated that Durbin-Watson value should not be lower than 1.5 or higher than 2.5, but in between these two values. In our study the Durbin-Watson was 2.01 for all multiple regressions, which is lower than the standard accepted value that is 2.5, which means that the assumption was not violated. Q-Q plots, which refer to Linearity, were checked and it could be stated that the linearity assumption was not violated. Considering the assumption of *homoscedasticity,* this was checked by a scatterplot of

errors (i.e. standardized residuals) and it was found that this assumption, was not violated, either. The last assumption, refers to *multicollinearity* and this was checked with Pearson correlations. According to Field (2009), Tolerance values should not be below 0.2 and VIF value should not be below 10, and in this study Tolerance values were around 0.9 and VIF's values were above 10. Additionally, both Cohen (1969) and Field (2009) stated that *multicollinearity* could be also checked by scanning a correlation matrix, which consists of predictor variables and see if any predictor correlate very high (i.e. above .80 or .90). Moreover, the authors considered that if there was any variable with a correlation above .80 or .90, this variable should be eliminated from the regression model.

Prior to conducting a hierarchical multiple regression, the relevant assumptions were tested. Firstly, the sample size was considered appropriate (N= 1756) for having 15 independent variables, which were included in the analysis, and, therefore, it was adequate to expect a large or medium effect (Tabachnick, Fidell, & Osterlind, 2001). Secondly, the assumption of multicollinearity was assessed by conducting Spearman's Correlation coefficients. The results from the correlation table, among the independent variables, showed that no independent variables were highly correlated. The assumption of multicollinearity has been met, as all the collinearity statistics (i.e. Tolerance and VIF) were within accepted limits (Coakes, 2005; Hair, Black, Babin, Anderson, & Tatham, 1998). The scatterplots and residual showed that the assumption of linearity, normality and *homoscedasticity* were all satisfied (Hair et al., 1998, Pallant, 2001) (Table 6.3).

Table 6.3.: Pearson's Correlations coefficients between predictors in Study 1 (N=1756)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	-													
2. Gender	-.00	-												
3. Current place of living	.15***	-.01	-											
4. Inconsistent parenting	-.12***	.08*	-.19***	-										
5. Involvement parenting	-.13***	.06*	.02	-.02	-									
6. Control parenting	-.22**	.14*	-.05*	.22***	.61***	-								
7. Warmth parenting	-.11***	.05*	.01	-.03	.73***	.43***	-							
8. Family support	.06	-.00	.06*	-.14***	.46***	.20***	.50***	-						
9. Friends support	.05	.01	.11***	-.09***	.25***	.13***	.24***	.47***	-					
10.Significant other support	.03	.16***	.05*	.23	.27***	.17***	.31***	.59***	.54***	-				
11. Mother care	-.02	.05*	-.15***	.40***	-.43***	-.21***	-.44***	-.46***	-.32***	-.23***	-			
12. Mother protection	-.06***	-.15***	.10***	-.37***	.09***	-.12***	.17***	.21***	.21***	.10***	-.41***	-		
13. Father care	.04	.07***	-.10***	.25***	-.38**	-.20***	-.36***	-.35***	-.25***	-.18***	.49***	-.29***	-	
14. Father protection	.01	-.20***	.08*	-.27***	.11**	.08*	.12***	.19***	.17***	.05*	-.36***	.58***	-.43***	-

Note: The values that are in bold are those that have been removed from the regression model as they have a correlation higher than .80

6.5. Results

6.5.1. Prevalence of mental health problems among adolescents

Findings on the Youth Inventory 4R showed that the most common mental health problems were Social phobia (24.6%), followed by Dysthymia (23%) and ADHD (22.6%) (Table 6.4).

Table 6.4: Prevalence of mental health problems among Romanian adolescents (N=1754)

Youth Inventory 4R	Total n (%)
ADHD	385 (22.6%)
Conduct problem	213 (12.3%)
Oppositional defiant	241 (13.9%)
Generalized anxiety	126 (7.3%)
Specific phobia	357 (20.3%)
Panic attack	345 (19.7%)
Social phobia	431 (24.6%)
Separation anxiety	62 (3.5%)
Major depression	162 (9.4%)
Dysthymia	400 (23.0%)
Substance use	292 (16.7%)

Findings on the SDQ showed a somewhat lower prevalence. As shown in Table 6.5, 19.0% of the adolescents could be classified as having “borderline” and “abnormal” range. Specifically, 9.2% of the adolescents could be classified in the “abnormal range” and 9.8% could be classified in the borderline range. Amongst the difficulty subscales, emotional problems and hyperactivity were the most common; 7.3% of the adolescents were in the abnormal range on each of these subscales.

Table 6.5. Number of participants in the normal, borderline and abnormal ranges on SDQ

SDQ subscales	Normal range		Borderline range		Abnormal range	
	Raw score	Exact %	Raw score	Exact %	Raw score	Exact %
Emotional problems	0-7	86.1	8	6.6	9-10	7.3
Conduct problems	0-4	86.1	5	8.8	6-10	5.1
Hyperactivity-inattention	0-5	80.7	6	12.0	7-10	7.3
Peer problems	0-5	86.5	6	7.1	7-10	6.4
Prosocial behavior	10-5	86.5	4	5.4	3-0	8.1
Total difficulties	0-19	81.0	20-22	9.8	23-32	9.2

To examine the prevalence of mental health problems by gender and age groups, the cut-off points of each Youth Inventory 4 R, as well as for all SDQ subscales (i.e. emotional problems, conduct behaviour, hyperactivity, peer problems, pro-social behaviour and SDQ total difficulties score) were used.

On Youth Inventory 4 R, further analyses revealed that girls from the second age group (15-16 years old) had higher prevalence rates on ADHD problems (13.4%), Oppositional defiant (9.1%), Specific phobia (17%), Panic attack (17%), Separation anxiety (17.8%) and Dysthymia (18.3%), compared to boys and to other age groups. In contrast, boys reported higher prevalence scores on Conduct problems (7.7%) and Substance use (12.4%) than girls. The most common mental health problems among girls, aged between 15 to 16, were dysthymia and social phobia; these findings were supported by the prevalence rates on Emotional problems (17.5%) as measured using SDQ, for the same age group.

Girls showed higher frequency on Dysthymia (15.5%), Social Phobia (16.8%), Panic attack (15.2%), Specific Phobia (15.4%), Oppositional defiant (8.2%), Major Depression (7.3%), Generalized anxiety (5.9%) and ADHD (12.1%) compared to boys. In contrast, boys reported higher prevalence rates for Substance use (11.4%) and Conduct problems (8.2%).

On SDQ, total difficulty scores were significantly higher in girls than in boys. Within the SDQ, girls also higher scores on all the SDQ subscales except for prosocial behaviour which was surprisingly higher in boys than girls.

6.5.2. Gender effect on adolescents' mental health problems

Multivariate Analysis of Variance (MANOVA) was conducted in order to identify if there is a significant difference between common mental health problems and gender. Therefore, mental health problems (as measured using SDQ and Youth Inventory 4R) were used as dependent variable and gender was the independent variable. The results indicated that the Box's M test was significant, which indicates that the homogeneity of variance and covariance matrices assumptions was violated, and therefore Pillai's Trace (V) was taken into account while analyzing the results.

The multivariate analysis of variance indicated a significant main effect of gender, ($V = .23$; $F_{71,1642} = 45.17$, $p < .001$, $\eta^2 = .23$) on the Youth Inventory 4R symptoms.

Table 6.6: Gender effect on adolescents Youth Inventory 4R and SDQ

Youth Inventory 4R symptoms	Boys n = 825		Girls n = 829				
	Mean	SD	Mean	SD	F	P	η^2
Social phobia	1.07	1.19	1.80	1.53	119.59	.00**	.06
Dysthymia	7.60	3.74	9.95	4.58	136.89	.00**	.07
ADHD	17.58	8.30	19.44	9.04	19.75	.00**	.01
Specific phobia	0.64	0.73	1.19	.94	186.49	.00**	.09
Panic attack	0.55	0.69	1.12	0.99	188.26	.00**	.09
SDQ							
Internalizing behaviour	4.75	3.06	7.19	3.37	249.49	.00**	.12
Emotional problems	3.11	2.39	5.23	2.53	321.55	.00**	.15
Peer problems	2.94	1.78	3.36	2.08	19.89	.00**	.01
Externalizing behaviour	5.25	2.73	5.71	2.98	11.01	.00*	.00
Conduct problems	2.70	1.16	2.66	1.62	0.18	.67	.00
Hyperactivity	3.62	1.87	4.00	2.02	17.42	.00**	.01

*p< .05 , **p< .01 , ***p< .001

Follow-up univariate ANOVAs on each symptom (Table 6.6) revealed significant gender effect on SDQ subscales of Emotional Problems, Peer problems, Hyperactivity, as well as on Youth Inventory 4R subscales of ADHD, Specific phobia, Panic Attack, Social Phobia and Dysthymia. Thus, girls compared to boys had significantly higher scores on all the above problems except for conduct problems.

6.5.3. Age effect on adolescents' mental health problems

To examine the impact of age on mental health problems, the sample was divided to three age groups according to the Romanian education system (the participants aged between 13 to 14 represent the Junior High School grades, those aged between 15 to 16 are attending the Upper of the Secondary Education and the last age group (17 to 18 years) represent adolescents who were going to attend the General Certificate of Secondary Education). Another reason to divide the participants into three age groups was that each group was at a critical stage and experiencing different social environment changes, such as participants from the second age group (15 to 16) were are changing schools, while the other two age groups were both preparing for different national exams.

In order to identify if there are any significant differences between age and mental health problems, the Multivariate Analysis of Variance (MANOVA) was conducted. The results indicated that the Box's M test was significant, which indicated that the homogeneity of variance and covariance matrices assumptions was violated, and therefore Pillai's Trace (V) was taken into account while analyzing the results. Mental health problems were the dependent variables, while age was the independent variable. The results revealed significant age effect on mental health problems as measured using the Youth Inventory 4R and the SDQ. This finding showed that the older age group reported higher scores compared to the other two groups, V = .08; $F_{24,1664} = 2.92$, $p < .01$, $\eta^2 = .04$.

Table 6.7: Age effect on adolescents Youth Inventory 4R and SDQ

Youth Inventory 4R symptoms	13-14 years old n = 108		15-16 years old n = 581		17- 18 years old n = 156				
	Mean	SD	Mean	SD	Mea	SD	F	p	η^2
Social phobia	1.29	1.35	1.40	1.40	1.56	1.48	3.78	.02*	.00
Dysthymia	7.73	4.41	8.70	4.34	9.43	4.20	13.19	.00**	.01
ADHD	16.01	8.39	18.26	8.44	20.2	9.09	20.36	.00**	.02
Specific phobia	0.79	0.85	.90	.87	.99	.92	4.35	.00**	.09
Panic attack	0.79	0.83	.80	0.89	.93	.94	3.84	.02*	.00
SDQ									
Internalizing behaviour	5.92	3.50	5.79	3.47	6.35	3.34	4.42	.01*	.00
Emotional problems	4.12	2.61	4.05	2.71	4.42	2.64	3.20	.04*	.00
Peer problems	3.27	2.11	3.11	1.97	3.16	1.81	.64	.52	.00
Externalizing behaviour	5.52	2.97	5.42	2.80	5.59	2.95	.57	.56	.00
Conduct problems	2.61	1.69	2.65	1.60	2.77	1.62	1.05	.35	.00
Hyperactivity	3.79	1.97	3.79	1.91	3.84	2.03	.08	.91	.00

*p< .05 , **p< .01 , ***p< .001

On Youth Inventory 4R, there were significant age differences on Social phobia, Dysthymia, ADHD, Specific phobia, Panic attack; on SDQ, significant age differences were found for Emotional Problems and Internalizing problems. The findings showed that the 17-18 year olds reported higher scores on all the above variables, compared to the other two age groups (i.e. 13-14 and 15-16 year olds). No significant age differences were found for Peer Problems, Conduct problems and Hyperactivity.

6.5.4. Gender and Age effects on adolescents' mental health problems (combined)

The Multivariate Analysis of Variance (MANOVA) was conducted to identify if there are any gender and age differences on mental health problems. The Box's M test was significant, which indicates that the homogeneity of variance and covariance matrices assumptions was violated, and therefore Pillai's Trace (V) was taken into account while analyzing the results

.

The multivariate analysis of variance indicated a significant main effect of gender and age for Dysthymia and Social Phobia (V = .17; $F_{22,1639}$ = 1.29, p = .163, η^2 = .00). Specifically, these results revealed that girls from the older age group (17 to 18) reported higher scores on Youth Inventory 4R and SDQ than boys. However, older boys reported higher scores for Conduct problems than younger boys and girls.

6.5.5. Predictors of mental health problems

In order to test the 4th hypothesis, a hierarchical multiple regression was conducted, to examine potential predictors of social phobia and dysthymia– which were the two most common disorders. The potential predictors included socio-demographic information and family factors (such as: Parenting styles, Social support and Parental bonding) which predicted social phobia and dysthymia. Before conducting the hierarchical multiple regressions, the correlation between all predictors was tested (Table 6.4, Section 6.4.5.1.).

6.5.5.1. Predictors of Dysthymia

A four-stage hierarchical multiple regression was conducted to examine which family factors and socio-demographic factors (i.e. age and gender) will predict Dysthymia. Dysthymia was used as the dependent variable and socio-demographic and family factors as independent variables (Table 6.8).

Table 6.8: Summary of hierarchical multiple regression analysis of variables that predict dysthymia

	Dysthymia			
	R^2	β	Standard Error	*t*
Step 1	.082			
Age		.11	.08	4.56**
Gender		.26	.20	11.08**
Step2	.124			
Age		.11	.08	4.63**
Gender		.25	.20	10.91**
Inconsistent parenting		.10	.03	4.01**
Control parenting		.06	.02	2.08*
Warm parenting		-.14	.04	-4.35**
Step 3	.136			
Age		.08	.11	4.78**
Gender		.20	.25	10.43**
Inconsistent parenting		.03	.08	3.41*
Control parenting		.02	.06	2.11*
Warm parenting		.04	-.12	-3.60**
Friends' support		.02	-.10	-3.69**
Step 4	.153			
Age		.08	.10	4.26**
Gender		.21	.23	9.66**
Inconsistent parenting		.03	.06	2.36*
Warm parenting		.04	-.11	-3.31*
Friends' support		.04	-.09	-3.26*
Mother care		.02	-.09	-2.92*
Mother protection		.02	-.13	-4.25**
Fater care		.01	.05	2.04*

*p < .05, **p < .001

The results indicated that socio-demographic factors (age and gender) and family factors significantly predicted Dysthymia, as explaining 8.2% of the variance (R^2 = .082), (F (3, 1617) = 48.31, p < .001). Therefore, only age ($\beta = 0.11$; t = 4.56, p < .01) and gender ($\beta = 0.26$; $t = 11.08$, $p < .01$) significantly predicted dysthymia. In the second step, parenting style accounted for a significant change in variance (ΔR^2 = .042; ΔF (4, 1613) = 19.13, p < .01). In this step, apart from age and gender,

inconsistent parenting ($\beta = 0.10$; $t = 4.01$, $p < .01$), control parenting ($\beta = 0.06$; $t =$ 2,08, $p < .05$) and warmth parenting ($\beta = -0.14$; $t = -4.35$, $p < .01$) significantly predict social phobia. In the third step, social support accounted for a significant change in variance ($\Delta R^2 = .012$; ΔF (3, 1610) = 7.34, $p < .01$). In this step, only friends' support ($\beta = 0.02$; $t = -3.69$, $p < .01$) significantly predicts the outcome. In the last step, mother care ($\beta = 0.02$; $t = -2.92$, $p < .05$), mother protection ($\beta = 0.02$; $t = -4.25$, $p < .01$) and father care ($\beta = 0.01$; $t = 2.04$, $p < .01$), accounted for a significant change in variance ($\Delta R^2 = .017$; ΔF (4, 1606) = 8.10, $p < .01$). All six predictors from this model explained 15.3% of the variance ($R^2 = .153$), (F (14, 1606) = 20.68, $p < .001$). In other words, the results showed that older girls whose parents were inconsistent, lacking parental warmth, as well as friends' support, mother and father care, but having an overprotected mother, reported higher scores for dysthymia.

6.6. Discussion

The main aims of this study were to identify the prevalence of mental health problems among adolescents from Moldova area, in Romania, aged between 13 to 18 years old, from community setting. Another aim was to examine the predictors of mental health problems. The findings indicated that a higher percentage of the adolescents reported to have higher scores on Emotional problems (21.2%) and on the Total difficulties score (19.8%), as measured using the SDQ. According to Youth Inventory 4R, the findings revealed that the most common mental health problems were Social phobia (24.6%), followed by Dysthymia (23%). The first hypothesis was confirmed.

Our findings on the prevalence of the Total difficulties score of 19.8% was in line with results found in studies conducted in other countries, where the prevalence ranging from 4.8% to 42% were reported in Denmark (Elberling, Linneberg, Olsen, Goodman, & Skovgaard, 2010), Ireland (Greally et al., 2009; 2010), India (Banerjee, Bhat, & Chatterjee, 2015), Iran (Alavi, Mohammadi, Joshaghani, & Mahmoudi-Gharaei, 2010; Arman et al., 2012). However, the prevalence found in our findings was similar to the Iranian study (please see Table 3.3, Chapter 3). It could be argued that Romanian culture is closer to Iranian's culture than to Danish or Irish culture. According to Hitchins (2014), since the 20th century, there has been a sustained relation between Romania and Iran.

These differences in prevalence rates between countries could be due to true difference in terms of differences in cultural norms and values, or it could be related to differences symptoms reporting. These differences may also be related to cultural differences (General, 2001) on stigmatization attitudes towards mental disorders. These attitudes can be related to the fact that Romanians with mental health disorder, are more likely to be discriminated than those with mental health problems in another EU country (Ciumageanu, Craciun, Popescu, Sfetcu, & Miclutia, 2010; Stanculescu, Nitulescu, Preotesii, Ciumageanu, & Sfetcu, 2008).

Findings from the Youth Inventory 4R scores revealed that the most common mental health problems were Social phobia and Dysthymia which have been reported in numerous studies (Costello et al., 2011; Essau & Chang, 2009; Jonson & Wolke, 2013). Therefore, the second hypothesis was confirmed.

Further analysis revealed that girls scored higher than boys in several subtypes of anxiety disorders such as Separation anxiety, Social phobia, Panic attack, Specific phobia, and Generalized anxiety. These results are in line with previous findings that reported that girls had higher prevalence rates of anxiety symptoms compared to boys (Duchesne & Ratelle, 2016; Essau et al., 2012; Essau et al., 2014). These findings could be explained by the fact that girls tend to have genetic predispositions and they react differently to biological and social changes during their puberty (Silberg et al., 2001). Cyranowski et al., (2000) stated that girls are at a higher risk to develop anxiety if their needs regarding interpersonal affiliation are not met (i.e. during puberty girls have higher level of oxytocin, a hormone related to reproduction and caregiving, which could increase their need for affiliation).

Additionally, girls scored higher for dysthymia and major depression than boys. These findings are similar to previous studies conducted by Essau (2010) and Salk, Petersen, Abramson, & Hyde, (2016), who also found that females reported two times more than males that they experience depression. It was argued that these gender differences may be related to hormonal changes and the way they respond to stress; the latter suggest that girls tend to become more sensitive and pay more attention to their emotions than boys (Cyranowski et al., 2000; Essau, 2010; 2014; Hankin et al., 2007). Therefore, it could be stated that the third hypothesis is partially confirmed with girls reporting higher scores for Internalizing problems compared to boys. Surprisingly, our results revealed that ODD and ADHD were also higher in girls than boys supporting previous results (Essau et al., 2014; Hankin et al., 2007; Pine et al., 1998; Silberg et al., 2001). One could argue that girls tend to express their anger and temper outbursts through excessive behaviour or present irritable manifestations which are common symptoms for both anxiety and depression (Bøe,

Hysing, Skogen, & Breivik, (2016).

Our findings revealed that both girls and boys aged between 15 to 16, reported higher prevalence rates for almost all mental health problems compared to the other two age groups (i.e. 13 to 14 and 17 to 18). These findings are in line with previous studies, which found that the older age group reported higher scores for both Internalizing and Externalizing behaviour than the younger age group (Essau et al., 2014). The results on the association between age and mental health problems have not been consistent across studies. For example, some studies have reported the younger age groups are more likely to suffer from hyperactivity compared to the older age groups (Arman et al., 2012; Mohammdi et al., 2014; Slobodskaya, Akhmetova, & Ryabichenko, 2007). A possible reason for the age differences on mental health problems could be associated with two factors: the transition from childhood to adulthood (Johnson & Wolke, 2013) and school transition (Nielsen et. al, 2017). The former transition is considered to be the period of rapid growth that is related to major social, physical and emotional changes; indeed, studies have reported this period to be linked to the onset of several mental health problems (Costello et al., 2003; Ford et al., 2003; Kessler et al., 2005). The latter transition refers to the age group 15 to 16, when the children are changing schools, moving from Junior to Senior High School in Romania. According to Nielsen and colleagues (2017) children who are experiencing these transitions are at higher risk to suffer from different mental health problems. Furthermore, according to our findings, girls from the older age groups reported higher scores for both Internalizing and Externalizing behaviour (measure with SDQ) than boys. Hines (2007) argued that girls have difficulties in adjusting to the new school environment, which makes them vulnerable to developing emotional and behavioural problems.

The 4th hypothesis could be partly supported. The only factors which significantly predicted social phobia were: gender, age, friends support and mother protection. In line with previous studies, our findings seemed to suggest that low social support could determine adolescents to feel insecure in different situations, which increase their chance to develop social phobia (Väänänen et al., 2014). In addition, La Greca and Lopez (1998) and McDonald et al. (2010) reported that adolescents lacking friends' support were more likely to suffer from social anxiety. Our findings that showed girls from the older age group to be more likely to suffer from social phobia was in line with previous results (Gren-Landell et al., 2009; Wittchen et al., 1999). Furthermore, we found that girls from the older age group, with low friends' support, and having an overprotective mother were at a high risk to suffer from social phobia.

Our results revealed that having an overprotective mother predicted Social phobia. Thus, our findings did not support Chao's argument (1994) that overprotective parents have positive effects upon adolescents' outcomes; however, Chao's statement was based on Asian families. On the other hand, Pedersen (1994) reported that adolescents who suffer from anxiety and depression, reported high level of parental control (overprotection). In addition, Ngai (2015) defined the overprotective parent, in Western countries, as being over-controlling and over-intrusive behaviour towards their children. This behaviour makes these adolescents depend on their parents and it does not allow them to cope with challenging situations and to become independent individuals. Indeed as argued by several authors adolescents with overprotective parents had a increase risk of developing mental health problems, such as anxiety and depression (Canetti et al., 1997; Indumathy & Ashwini, 2017; Ngai et al., 2013).

To sum up, these findings could be related to the fact that those who suffer from Social phobia and Dysthymia are more likely to find support in their families and significant other, rather than seek help in friends, as they are scared of being rejected by their peers, or they might feel not being liked by them (Väänänen et al., 2014). It could be argued that in Romanian families parents try to get involved as much as possible in children's lives up to their late 20s. Sometimes this overprotective parenting style is more commonly practiced by mothers, who are trying to overcontrol their adolescents' lives. Apart from their parents, most adolescents have significant others who they can rely on when they need guidance and support.

Further analysis on gender effect on family factors showed that there was a significant gender effect on significant other support, parenting style (inconsistent parenting, involvement and control parenting) and parental bonding (mother care, father and mother over protection); thus, the fifth hypothesis was supported. These findings showed that girls reported significant higher scores than boys for all these factors. Previous findings supported our findings that girls reported higher scores for significant other support (Bettge et al., 2008; Katainen et al., 1999; La Greca & Lopez, 1998; Väänänen et al., 2014). Facio and Batistuta (2001) argued that these results are due to the fact that girls are more focused on building up dyadic relations, which makes them have stronger connections, while boys focus on larger groups of friends. Our finding that girls reported higher score on almost all parenting styles was not clear. A reason for these results could be that within Romanian families, boys are more independent than girls, and their parents allow them to come later at night and go out alone. For girls the situation is different, as they are not allowed to go out by

themselves until they are 16 or even 17 years old; moreover, they are not allowed by their parents to stay till late during nighttime.

6.7. Limitations and Future Recommendations

The present study relied on adolescents' self-reports. However, several studies have shown the inconsistency of parental, teacher and self-reports (Kamphaus & Frick, 1996; Van Roy, Groholt, Heyerdahl, & Clench-Aas, 2010; Verhulst & van der Ende, 1992), which indicates that self-reports are an important assessment method for assessing emotions and behaviours that may not be directly observable. Future studies with a multi-method assessment matrix, which could made up of observation and interviews data, as well as parental and teacher reports.

The sample for the present study was made up of adolescents who were been recruited from various schools in Iasi and the surrounding area. Thus, it might not be possible to generalize the results to all the adolescents in Romania or to adolescents who drop out of school. Consequently, future studies should recruit adolescents from other settings (e.g., clinical setting).

6.8. Summary

The chapter presents study 1, which aims were to examine the prevalence, correlates and predictors of mental health problems among adolescents in regions of Moldova. The finding showed a high prevalence of mental health problems (in particular anxiety and depression) among adolescents in Romania. Anxiety and depression were significantly associated with gender, age, and several family factors. The latter suggested that parental overprotection (especially mother overprotection),

and social support (especially friends' support) were significant predictors of adolescents' mental illnesses.

The findings could be used as an important source for policy makers who make decisions about allocating resources to help prevent the development of mental health problems among adolescents.

CHAPTER 7: PSYCHOLOGICAL WELL-BEING OF LEFT BEHIND ADOLESCENTS IN ROMANIA

(STUDY 2)

7.1. Overview

The main objective of this chapter is to review previous studies on the impact of parental migration on children's psychological well-being. The other aim is to present our findings on the characteristics of left behind adolescents (LBAs), including their living arrangement, daily activities, and psychological well-being.

7.2. Introduction

Economic migration not only have an impact on those who work abroad but also those who are being left behind, in particular their children (Carballo, Divino, & Zeric, 1998). According to numerous authors, parental migration could impact their children at emotional, mental and physical levels (Adhikari, Jampaklay, Chamratrithirong, Richter, & Pattaravanich, 2012). Migration has both negative and positive impact on both groups.

Previous research has focused on the positive aspect of migration, such as: remittances, health care, education. For example, in a study in South Africa (Kahn et al., 2003), migration was found to enhance the well-being of adolescents with migrant parents. The positive aspect of migration was related to remittances (i.e. money sent home by the migrant parent/s), which helps by ensuring a better nutrition and appropriate health care. In support, other studies reported that adolescents from

migrant families have better health and psychological development (Adhikari et al., 2012; Kuhn, 2003; Salah, 2008).

On the other hand, other studies have focused on the negative impact of migration on left behind adolescents. Salah (2008) found that even though remittances were perceived as a positive aspect of migration, these left behind children and adolescents often do not receive the appropriate care or treatment on time. Thus, they tend to face a higher risk to develop mental health disorders.

7.2.2. Gender of the migrant parent as a risk factor for mental health problems

In a study by Hugo (2002), children who were left behind by their mothers were reported as having impairment in their social and psychological development, and that they reported feeling lonely and had low school achievements. In support, a study conducted in Sri Lanka (Save the children, 2006), reported that the absence of the migrant mothers (as compared to their migrant fathers) has a detrimental impact on their children and that this impact is more obvious in boys than in girls; specifically, boys had lower school performances and attendance compared to girls. It was argued that the support they should receive from their father, as the main caregiver, was not much related to their school activities (e.g., homework). Moreover, it was found that these adolescents had emotional and behaviour problems. However, some other studies have not supported the findings of Hugo and the Save the Children. For example, a study conducted in Mexico (Aguilera-Guzman, Snyder, Romero, & Medina Mora, 2004) that examined the extent to which fathers' absence,

due to migration, have an impact on adolescents' mental health status indicated that the father's absence was not the main risk factor for mental health problems; an important finding was that it was the gender of the home alone adolescent that turned out to be an important risk factor. They concluded that the association between left behind adolescent's gender and father absence would increase the risk of experiencing child abuse, high dropping out of school, and substance use.

A study in China (Gao et al., 2010) found that among left behind children, boys were at a higher risk of smoking tobacco, suicide ideation or of internet addiction compared to girls. Girls, on the other hand, were at a higher risk of feeling unhappy, having a suicidal plan or wanting to leave their homes. Therefore, it was concluded that one of the most common mental disorders among left behind children is depression (Jones, Sharpe, J., & Sogren, 2004; Pottinger, 2005).

7.2.3. Mental health status among left behind adolescents

Adhikari et al. (2012) used SDQ instrument to identify the prevalence rates of mental health problems among 519 left behind children in Thailand. The findings indicated that 12.7 % reported to have abnormal scores for SDQ total difficulties score, 20% had hyperactivity, 16% reported to have conduct problems, 13% reported to have pro-social behaviour. A small percentage of these children had emotional problems (5%) and peer problems (5%). The authors concluded that one in ten children who are left behind by their migrant parent(s) were at higher risk to experience mental health problems compared to children from non-migrant families. Furthermore, they found that children from the younger age group were at a higher

risk to develop mental health problems compared to those from older age groups. In interpreting these findings, the authors argued that the older children might have received higher support from their peers, which led them to have lower risk of developing mental health problems.

Fan et al.'s study (2010) in China found that left behind children who had a higher risk to develop emotional and behavioral problems were reported to have the following characteristics: being left behind at an early age, being left behind for longer period, being in the care of younger caregivers, or being with a caregiver with poor education and low income. Moreover, girls were found to have higher emotional problems and more pro-social behaviour compared to boys; on the other hand, boys had more hyperactivity problems than girls. Graham and Jordan (2011) compared the mental health status of left behind children (N= 3.876, aged under 12) from 4 countries (Indonesia, Philippines, Thailand and Vietnam). Children from Indonesia and Thailand whose fathers worked abroad were more likely to develop mental health illnesses (e.g., emotional and conduct problems), compared to the children from intact families (i.e. non-migrant families). However, left behind children (LBC) from the Philippines indicated that neither children with migrant mothers, nor children with migrant fathers were less likely to develop emotional or conduct problems, compared to those from non-migrant families; furthermore, these children did not report higher scores in anxiety or to feel less lonely compared to those from intact families. Based on the SDQ cut off scores 30% of the LBC in Indonesia have a higher risk of developing emotional problems, and 53% of LBC in Thailand face a higher risk of having conduct problems than those from non-migrant families (Graham & Jordan,

2011). Overall, this study (Graham & Jordan, 2011) showed that 19.2 % of LBC children have mental health problem.

Wang, Hesketh, & Zhou (2015) focused on emotional and behaviour problems among 671 LBC in the rural areas in China, and the impact of parental migration on their psychological status, Approximately, 11% of these adolescents had emotional problems, 12% had conduct problems, 13% had hyperactivity, 39% had peer problems and 90% had pro-social behaviour. These authors argued that it was the separation from parents that had a detrimental impact on LBC, rather than parental migration per se.

7.2.4. Why is it so important to do research on migration?

Although migration has long been known to have an impact on the lives of the children who are left behind for a long time, it was only in the early 2000s that studies on transnational families began to be published by Bryceson & Vuorela in 2002 (as cited in Mazzucato, 2014). Previous studies had focused mainly on the people who decided for labour migration, rather than on the persons who were left behind (De Castro, Gee, & Takeuchi, 2008; Lu, 2010). However, children are the ones who are suffered most due to parental migration, and it is an urgent need to acknowledge what the parental migration impact on them is. Furthermore, even though the number of children who are left home alone is a common phenomenon in developing countries, there is hardley any research that examined this phenomenon. As argued by Smeekens et al. (2012) little is known about the impact of parental migration and the factors that can be associated with its negative impact on children's psychological well-being.

7.3. Research questions and hypothesis

Despite the high number of LBAs in Romania, information about their living arrangement, daily activities, and their psychological well-being is unknown.

Therefore, to make up for this gap, this study aims to address the following questions:

1) How many of the LBAs have both parents working abroad? Among those LBAs whose parents are both abroad, what are the most common patterns of living arrangement (e.g., how many of them live with their grandparents or with other relatives, live with their neighbours, or live alone)?
2) How frequent are mental health problems among LBAs? Among LBAs with mental health problems, which problems are the most common?
3) What factors are associated with mental health problems among LBAs. The factors under investigations include social support, parenting styles, parental bonding, and factors that are specific to parental migrant such as type and frequency of contact.

The hypotheses to be explored in this study are four folds: 1) Based on NGOs reports, about half of the LBAs will have both parents working abroad; half of these children are expected to be living with their relatives, and the rest either live with their neighbors or alone; 2) Up to 50% of the LBAs will have a mental health problem, mostly anxiety and depression; 3) Socio-demographic and family factors (Parenting styles, Social support and Parental bonding) will be significantly associated with mental health problems.

7.4. Methods

7.4.1. Participants

A total of 889 adolescents, aged 13 to 18 years (M=15.84, SD =1.34), participated in this study, of which 438 were boys (49.3%) and 451 were girls (50.7%). A high percentage of participants were from the urban areas (73.8%) (Table 7.1.).

Table 7.1: Socio-demographic characteristics of LBAs

	N	%
Gender		
Boys	438	49.3
Girls	451	50.7
Age	141	15.9
13 – 14 years	452	50.8
15 – 16 years	296	33.3
17 – 18 years		
Mean (*SD*) 15.84 (1.34)		
Grade	181	20.4
7^{th} -8^{th}	481	54.1
9^{th} – 10^{th}	224	25.2
11^{th}		
Region of living		
Rural	233	26.2
Urban	656	73.8

7.4.2. Procedure

Participants for this study consisted of a subsample of participants in Study 1, being focus on adolescents whose parent(s) work abroad. Out of the 1756 adolescents who participated in Study 1, 889 reported having one or both parents who worked

abroad. Therefore, analysis of this study (Study 2) will focus on these 889 adolescents.

As the procedure and the instruments used were the same as in Study 1, having been described in detail in Chapter 5, they are not described in this Chapter.

7.4.3. Statistical analyses

Adjusted logistic regression models were run to determine the association between covariates with DSM-IV-R symptom categories. Models calculated for each diagnosis included age, gender and urbanity. Other covariates (number of people living in the house, time parents were abroad, frequency of contact with parents, who was working abroad, parenting styles, support perceived and parenting bounding) were also included in these models only if they appeared as significantly associated (p values <0.05) with the diagnosis. This was done to avoid over-fitting. Bivariate analyses to determine the differences between LBA with and without DSM-IV-R symptom categories included chi-squared test for categorical variables, and t-test for continuous variables. Thus, median and interquartile were calculated in each socio-demographic and family covariates and compared with non-parametric tests. Thus, each model for each clinical outcome (clinical diagnosis) could include different covariates at the same time, depending on the results of the bivariate analyses.

7.5. Results

7.5.1. Family arrangement and parental work status

A total of 421 and 326 adolescents had mothers and fathers working abroad, respectively. One hundred and forty adolescents had both parents who work abroad.

About half of parent(s) had been abroad for more than a year. The majority of the adolescents lived together with one of their parents (N=594; 66.8%). Most of the adolescents, who did not live with one of their parents, lived with their grandparents. Surprisingly, the results indicated that 21 of them lived alone (Table 7.2.).

Table 7.2: Family arrangement and parental work status

	Total *N* (%)	Boys *N* (%)	Girls *N* (%)
Parental migration			
Mother	421 (47.4)	191 (43.7)	229 (50.9)
Father	326 (36.9)	171 (39.1)	156 (34.7)
Both (father and mother)	140 (15.8)	75 (17.2)	64 (14.4)
Length of parents being away			
6 months	294 (33.8)	147 (34.4)	147 (33.2)
1 year	76 (8.7)	43 (10.1)	33 (7.4)
>1 year	500 (57.5)	237 (55.5)	263 (59.4)
Living arrangements			
Live with at least one parent	594 (66.8)	298 (68.7)	296 (66.8)
Live with relatives (aunts, uncles, cousins)	80 (9.1)	36 (8.3)	44 (9.9)
Live with grandparents	124 (14.1)	66 (15.2)	58 (13.1)
Alone	21 (2.4)	5 (1.2)	16 (3.6)
Siblings	58 (6.6)	29 (6.7)	29 (6.5)

A high percentage of the LBAs communicated on a regular basis with their parent(s). Specifically, 59.5% of the LBAs talked with the migrant parent daily; 24.6% of them talked with their migrant parent once a week.

Most of them (81.4%) used landline phone or mobile phone to contact their parent(s); others chose Skype (11.5%) or Facebook (5.2%) as a means of communicating with their parent(s) (Table.7.3).

Table 7.3: Frequency and method of communication with parent(s)

	Total *N* (%)	Boys *N* (%)	Girls *N* (%)
Frequency of communicating with parent(s)			
Every day	529 (60.2)	259 (60.0)	270 (60.4)
Once a week	219 (24.9)	114 (26.4)	105 (23.5)
2-3 times/week	80 (9.1)	38 (8.8)	42 (9.4)
Every 2 weeks	23 (2.6)	8 (1.9)	15 (3.4)
Every 3 weeks	28 (3.1)	13 (3.0)	15 (3.4)
Methods of communication with parent(s)			
Phone	724 (81.4)	346 (80.7)	378 (85.3)
Skype	102 (11.7)	57 (13.3)	45 (10.2)
Facebook	46 (5.3)	26 (6.1)	20 (4.5)
Remittances received			
Each month	694 (79.0)	331 (77.2)	363 (80.8)
Every 2-3 months	105 (12.0)	55 (12.8)	50 (11.1)
Every 6 months	35 (4.0)	22 (5.1)	13 (2.9)
Never	44 (5.0)	21 (4.9)	23 (5.1)

In terms of their school and social activities, slightly more than half (56.5%) of the adolescents spent 1-2 hours doing homework, and only 14.4% spent more than 3 hours. Almost half of the LBAs watched TV for 1-2 hours, and almost a third chose to read books, magazine or newspapers for the same amount of time. Approximately 46.2 % and 39.5% used Internet and Facebook for 1-2 hours, respectively (Table 7.4.).

Table 7.4: Hours spent doing the following activities

	0-1/2 hours *N* (%)	1 – 2 hours *N* (%)	3-5 hours *N* (%)
Doing homework	259 (29.1)	501 (56.5)	128 (14.4)
Watching TV	266 (30)	455 (51.3)	166 (18.8)
Reading books, magazines or newspapers	509 (57.2)	322 (36.2)	58 (6.5)
Playing computer/video games	300 (33.8)	347 (39)	242 (27.2)
Using Internet	169 (19)	410 (46.2)	309 (34.8)
Using Facebook	245 (27.6)	351 (39.5)	292 (32.8)
Using Skype	617 (70.1)	185 (20.8)	80 (9)
Taking care of brothers or sisters	593 (66.8)	140 (15.7)	155 (17.4)
Being home without an adult	356 (40.1)	235 (26.5)	297 (33.4)
Playing/hanging out in the neighborhood	367 (41.4)	270 (34.6)	249 (28.1)

7.5.2. Prevalence of mental health problems among left behind adolescents

The most prevalent symptom categories were dysthymia (51%) followed by ADHD (31.4%). The least frequent was DSM-IV-R symptom category of separation anxiety disorder, affecting only 3.9% of the sample. In terms of gender, girls were more likely than boys to have the symptom categories of ODD ($p < .01$), major depression ($p < .01$), dysthymia ($p < .001$), anxiety disorders ($p < .001$) and various subtypes of anxiety disorders including GAD ($p < .001$), specific phobia ($p < .001$), panic ($p < .001$), social phobia ($p < .001$), and separation anxiety disorder ($p < .05$). Boys on the other hand were more likely to suffer from symptom categories of conduct disorder ($p < .01$) and substance abuse ($p < .001$) than girls.

*7.5.3. Factors that are associated with risk of having mental health problem*s

Table 7.5 shows the adjusted Odds Ratios (aORs) and 95% Confidence Intervals (95% CI) for the association between DSM-IV-R symptom categories and covariates. Each logistic regression model included age, gender and urbanity, and those covariates which appeared as significantly related to that particular diagnosis in the bivariate analyses, with all of them introduced simultaneously in the regression model.

Girls presented higher risk than boys for having internalizing symptom categories: major depression, dysthymia and any anxiety disorders and their subtypes (i.e., GAD, specific phobia, social phobia, panic disorder). For example, girls were 3.65 times more likely than boys to have specific phobia and 2.54 times more risk for any anxiety disorders. Older adolescents were more likely to have a diagnosis of ADHD, dysthymia as well as any anxiety disorders and their subtypes (i.e., GAD, specific, social phobia) than younger participants. Those adolescents living in urban areas were less likely to have separation anxiety disorder. Time parents have been living abroad was only significantly associated with dysthymia in the bivariate analysis, and in the adjusted logistic regression model for dysthymia, adolescents whose parents have been more than one year living abroad were 1.5 times more likely to have dysthymia than those whose parents were abroad less than 1 year. The frequency of contact with parents was significantly associated with substance abuse and anxiety disorder in the bivariate analysis. But only having contacts each 3 weeks, compared with every day, increased the risk of having a substance abuse diagnosis.

Parenting styles, perceived social support, and parental bounding were significantly associated with all the DSM-IV-R categories in the bivariate analysis. In

the adjusted models, “inconsistency” parenting styles was found to increase the risk for depression and dysthymia. “Higher involvement” from parents significantly decreased the risk for ADHD, panic and substance abuse. Higher scores on “parental control” were related to higher risk for separation anxiety disorder, and “warmth” was protective against GAD and was a risk factor for specific phobia. Perceived social support was significantly associated with conduct disorder; higher scores on family support was related to higher risk for conduct disorder whereas higher support from significant others was related to lower risk.

Table 7.5. Multivariate logistic regression models for the DSM-IV-R symptom categories

	ADHD combined	Conduct disorder	ODD	GAD	Specific phobia	Social phobia	Panic	SAD	MDD	Dysthymia	Substance abuse	Anxiety
Female	1.22 (0.86-1.73)	0.37 (**0.21-0.65)****	1.47 (0.91-2.39)	2.45 (**1.46-4.10)****	3.65 **(2.39-5.56)*****	2.45 (**1.67-3.61)*****	3.86 (**2.48-6.01)*****	1.20 (0.50-2.88)	1.59 (**1.11-2.27)***	1.57 (**1.14-2.18)****	0.33 (**0.21-0.53)*****	2.54 (**1.67-3.89)*****
Age (years)	1.18 (**1.03-1.36)***	1.03 (0.84-1.27)	1.20 (0.99-1.45)	1.32 **(1.09-1.60)****	1.22 (**1.05-1.42)***	1.28 (**1.10-1.48)****	1.13 (0.97-1.33)	1.32 (0.95-1.83)	0.97 (0.84-1.11)	1.24 (**1.09-1.40)****	1.12 (0.94-1.34)	1.27 (1**.08-1.49)****
Urban	0.88 (0.60-1.29)	0.65 (0.38-1.13)	1.45 (0.82-2.54)	0.74 (0.45-1.25)	0.85 (0.55-1.32)	0.82 (0.54-1.24)	0.82 (0.52-1.29)	0.39 (0.17-0.91)*	0.94 (0.63-1.40)	1.18 (0.81-1.70)	1.67 (0.98-2.85)	0.80 (0.51-1.26)
Time parents have been abroad (ref. less 1 year)												
1 year										1.77 (0.97-3.20)		
> 1 year										1.47 (**1.04-2.08)***		
Frequency contact with parents. n (%)												
once a week											0.72 (0.42-1.22)	1.52 (0.97-2.38)
2-3 times week											0.99 (0.47-2.05)	1.11 (0.57-2.15)
each 2 weeks											2.00 (0.70-5.77)	1.12 (0.39-3.25)
Each 3 weeks											3.25 (**1.26-8.38)***	2.02 (0.79-5.17)
Parenting												
Inconsistency	1.04 (0.99-1.10)	1.05 (0.97-1.15)	1.05 (0.98-1.13)	1.02 (0.95-1.10)	1.02 (0.96-1.08)	1.04 (0.98-1.11)	1.01 (0.95-1.08)	0.83 (0.81-0.91)	1.09 (**1.03-1.15)****	1.07 (**1.01-1.13)***	1.05 (0.98-1.13)	1.02 (0.96-1.09)
Involve	0.93	0.90	0.93	0.97	0.92	0.95	0.91	1.05	0.99	0.96	0.88	1.00

	(**0.86-0.99)***	(0.80-1.01)	(0.84-1.03)	(0.88-1.08)	(0.84-1.01)	(0.87-1.03)	(**0.83-0.99)***	(0.86-1.28)	(0.92-1.07)	(0.89-1.03)	(**0.80-0.97)***	(0.91-1.09)
Control	1.01 (0.96-1.06)	1.03 (0.97-1.11)	1.03 (0.97-1.09)	1.04 (0.98-1.11)	1.01 (0.96-1.06)	1.05 (1.00-1.11)	1.03 (0.97-1.08)	1.30 (**1.14-1.49)*****	0.98 (0.93-1.02)	1.00 (0.96-1.05)	0.96 (0.90-1.01)	0.98 (0.93-1.03)
Warm Perceived Social Support	0.96 (0.88-1.03)	0.95 (0.84-1.06)	0.96 (0.86-1.06)	0.89 (**0.80-0.99)***	**1.11 (1.01-1.22)***	1.02 (0.94-1.11)	0.98 (0.89-1.07)	0.88 (0.73-1.07)	0.94 (0.87-1.02)	0.98 (0.91-1.06)	1.04 (0.94-1.15)	0.96 (0.87-1.05)
Family	1.00 (0.95-1.04)	1.07 (**1.0-1.14)***	0.98 (0.92-1.03)	0.95 (9.90-1.01)	0.96 (0.92-1.01)	0.98 (0.94-1.03)	1.00 (0.95-1.05)	1.02 (0.92-1.12)	0.98 (0.93-1.02)	1.00 (0.96-1.05)	1.02 (0.97-1.08)	0.98 (0.94-1.04)
Friends	1.00 (0.96-1.03)	1.00 (0.95-1.06)	0.96 (0.91-1.01)	0.96 (0.92-1.01)	1.01 (0.96-.05)	0.97 (0.93-1.01)	0.97 (0.93-1.01)	0.93 (0.86-1.00)	0.97 (0.93-1.00)	0.97 (0.94-1.01)	1.04 (0.98-1.09)	0.99 (0.95-1.04)
Significant other Parental bonding	0.99 (0.94-1.03)	0.93 (**0.87-1.00)***	1.01 (0.95-1.07)	1.02 (0.95-1.08)	1.01 (0.95-1.06)	0.97 (0.92-1.01)	0.99 (0.94-1.05)	1.00 (0.90-1.10)	1.01 (0.97-1.06)	1.03 (0.98-1.07)	0.95 (0.90-1.01)	1.00 (0.94-1.05)
Mum care	1.00 (0.97-1.03)	1.04 (0.99-1.08)	1.01 (0.97-1.05)	0.99 (0.96-1.03)	0.98 (0.94-1.01)	0.99 (0.96-1.02)	(**0.92-0.99)***	1.02 (0.95-1.09)	1.01 (0.98-1.05)	0.99 (0.96-1.02)	1.01 (0.97-1.05)	1.00 (0.97-1.04)
Mum overprotection	0.95 (**0.92-0.99)****	0.99 (0.93-1.05)	0.97 (0.93-1.02)	0.98 (0.93-1.03)	0.93 (**0.89-0.97)****	0.97 (0.93-1.01)	0.96 (**0.92-0.99)***	0.96 (0.88-1.06)	0.97 (0.93-1.01)	0.94 (**0.90-0.97)****	0.96 (0.91-1.00)	0.94 (**0.90-0.98)****
Dad care	1.01 (0.99-1.04)	1.03 (0.99-1.07)	0.99 (0.96-1.02)	0.99 (0.96-1.03)	0.97 (0.94-1.00)	1.00 (0.97-1.03)	1.02 (0.99-1.04)	1.05 (0.99-1.10)	0.99 (0.97-1.02)	1.02 (1.00-0.97)	0.99 (0.96-1.02)	1.01 (0.98-1.04)
Dad overprotection	0.99 (0.96-1.03)	0.97 (0.92-1.03)	0.99 (0.95-1.03)	0.97 (0.93-1.02)	0.99 (0.96-1.03)	0.98 (0.95-1.02)	0.97 (0.94-1.01)	0.98 (0.90-1.06)	1.02 (0.99-1.06)	1.00 (0.97-1.03)	0.99 (0.95-1.04)	1.00 (0.96-1.04)

Note= Odds Ratios (ORs) and 95% Confidence Intervals (95%CI) are presented. In bold, significant associations. * $p<0.05$; ** $p<0.01$; *** $p<0.001$
Covariates were introduced simultaneously in the logistic models. ODD: Oppositional defiant disorder; ADHD: Attention deficit hyperactivity disorder; GAD: Generalized anxiety disorder; MDD: Major depressive disorder; SAD: Separation anxiety disorder

7.6. Discussion

The main purpose of this study was to examine the living arrangements, activities, and psychological well-being of adolescents whose parent(s) work abroad (i.e. left behind adolescents: LBAs). Before discussing the findings, some limitations should be discussed. Firstly, the subjects were not recruited from a clinical sample and are based on Youth Inventory 4R cutoff score; an in-depth clinical evaluation needs to be considered before a clinical diagnosis is given. Secondly, the data were solely based only on the adolescents' self–report. Some authors argued that teachers or parents should be included as informants. However, other informants may not be the best informants as they are less aware of the internalizing problems of adolescents compared to externalizing problems (Essau & Barett, 2001; Hu, Lu & Huang, 2014).

Consistent with previous findings, the present study found that the LBAs have high levels of DSM-IV-R symptom categories (Jia & Tian 2010; Pottinger 2005). Thus, our first hypothesis was supported. The most common being dysthymia (51%). The main reason for the high rate of dysthymia is unclear. However, according to NGO reports LBAs felt being abandoned and rejected by their parents, and exhibited a high level of depressive and anxiety symptoms (Soros Foundation, 2007).

Parents who work abroad and leave their children in Romania are perceived negatively and are regarded as neglectful of their children. This has led to LBAs being stigmatized by their peers and by the society at large (Robila, 2011). One study (Robila, 2012) found that left behind children with both parents abroad, looked after by grandparents or by persons other than parents, reported to have no mental health problems.

Other common problems reported among LBAs included behavioural problems, drug and alcohol abuse (Salah, 2008). It has been argued that the high prevalence of behavioural problems among LBAs is related to a lack of parental monitoring and supervision (Demuth & Brown, 2004).

Perceived family support was associated with high risk for conduct disorder; however, previous findings on the association between parental support and externalizing problems have been inconsistent with some studies showing parental support to be related to few externalizing problems (Wills & Cleary, 1996), whereas some other studies failed to find this association (e.g., Licitra-Kleckler & Waas 1993; Van Loon, Van De Ven, Van Doesum, Hosman, & Witteman, 2015). Our finding could be explained by the mental health problem's severity, in that LBA with emotional or behavioural problems might represent severe cases which causes family members to offer much higher support. Conversely, LBAs who did not have any mental health problems were in less need of support from their relatives or their relatives did not consider it necessary to give them support.

Perceived support from peers appeared to be important for preventing mental health problems among LBAs. As reported in several studies, peer support among adolescents who have been exposed to negative events tended to have positive impact (e.g., van Harmelen, Gibson, St Clair, Owens, Brodbeck, & Dunn, 2016). The mechanism for this association is not well understood. It has been suggested that perceived peer support may have a positive effect on coping skills and self-esteem (Cohen & Wills 1985).

As reported in previous studies, young people who reported emotional and behavioural problems were more likely to report parental styles which involved inconsistency (Frick et al. 1993) and overprotection (Waite & Creswell 2015). Indeed, a series of studies by Patterson and

his colleagues (Capaldi & Patterson, 1994; Patterson, Reid, & Dishion, 1992) have, for example, shown that inconsistent parenting practices accounted for 30 to 52% of the variance in the development of antisocial behaviour. Other studies have also shown inconsistent parenting to be a powerful predictor of juvenile delinquent behaviour (e.g., Wasserman, Miller, Pinner, & Jaramillo, 1996).

The finding that showed "parental control" to be related to a high risk for separation anxiety disorder was of interest. Over-control is characterized by parental over-involvement and excessive regulation of the children's behavior, which several authors believed had an impact on the children's sense of self-efficacy, and limits their experience of novel situations (Rapee, 1997; Waite & Creswell 2015).

Similar to previous studies among adolescents in community settings (e.g., Essau et al., 2010), significantly more girls than boys had emotional problems such as anxiety and depression, whereas significantly more boys than girls had substance abuse. Among studies of home alone children, findings of mental health problems across gender have been inconsistent with some studies reported no significant difference between boys and girls (Leng & Park, 2010), whileas in some other studies, girls reported poorer mental health than boys (Wu, Lu, & Kang, 2015). While it is beyond the scope of this study to examine the reasons for this gender difference, gender socialization, social and hormonal mechanisms have been put forward as explanations for this difference (Cyranowski et. al, 2000).

The finding that parental migration had negative impact on LBAs' psychological well-being has important political implication for social and health service providers, as well as for policy-makers who provide funding for developing and implementing intervention programs to promote emotional wellbeing in young people in general and for LBAs in specific.

7.7. Summary

This chapter present findings of study 2, which focused on LBAs. Specifically, it explored the living arrangement of LBAs and their mental health status. The finding showed a high level of mental health problems among LBAs, with dysthymia being the most common. Family factors were related to various aspects of mental health problems among LBAs. Specifically, “inconsistency” parenting styles was found to increase the risk for depression and dysthymia. Parental “higher involvement” significantly decreased the risk for ADHD, panic and substance abuse. Higher scores on “parental control” were related to higher risk for separation anxiety disorder, and “warmth” was protective against GAD and was a risk factor for specific phobia.

CHAPTER 8: THE STABILITY OF MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS

STUDY 3

(Longitudinal study)

8.1. Stability of mental health problems

8.2 Longitudinal studies on anxiety disorders

Previous longitudinal studies concluded that when anxiety disorders have an early onset and if left untreated, they tend to become chronic and act as a risk factor for several disorders at adulthood (Bruce et al., 2005; Keller et al., 1992; Letcher, Sanson, Smart, & Toumbourou, 2012; Pine et al., 1998). Furthermore, Mathew, Pettit, Lewinsohn, Seeley, & Roberts (2011) reported that anxiety that is present during adolescence period, predicted major depressive disorder (MDD) in adulthood. These findings were supported by other studies conducted by Pine et al. (1998) and Woodward and Fergusson (2001). Additionally, Woodward and Fergusson (2001) found that those adolescents who experienced at least three types of anxiety disorders, reported high rates of MDD and substance dependence compared to peers without anxiety disorders in adulthood.

Essau et al. (2014) reported the results of their 16-year longitudinal study that examined the association between childhood and adolescence-onset anxiety and psychosocial functioning in adulthood. They also explored whether depression and substance use disorders in early adulthood could mediate the relationship between childhood-onset or adolescence-onset anxiety and psychosocial outcome at age 30. Results showed that participants with an adolescence-onset

anxiety tended to have a worse outcome in adulthood compared to those with an adolescence-onset anxiety. Specifically, childhood anxiety predicted only MDD in adulthood, whereas adolescence anxiety predicted depression, drug and alcohol use disorders in adulthood. When further adjusted for other forms of psychopathology before age 19 and childhood anxiety, these effects remained significant. This finding was interpreted as suggesting that there is a heterotypic continuity between adolescent anxiety and depression and drug and alcohol use disorders, which is not accounted for by homotypic continuity. Adolescent-onset anxiety predicted income, unemployment, maladjustment, poor coping skills, chronic stress and higher number of life events at the age of 30 (Essau et al., 2014).

However, other studies have reported positive course and outcome of anxiety disorders (Essau & Chang, 2009) as well. For example, approximately 82% of the children in Last, Perrin, Hersen, & Kazdin (1996)'s study recovered from their anxiety disorders at follow-up assessment. About two-thirds of children who recovered from their anxiety did so within the first year of follow-up. Of all the anxiety disorders the highest remission rate was that of separation anxiety, and the lowest was reported for panic disorder.

Thus, while some studies have shown anxiety disorders to have a negtaive and chronic course, other studies have shown a rather positive outcome. Differences in sample and time interval between the baseline and follow-up interview have been suggested as explanations for the inconsistent findings (Essau, Conradt, & Petermann, 2002).

8.3. Longitudinal studies on depression

Previous longitudinal studies on depression in adolescents have shown this disorder to have a chronic course and outcome (Essau & Chang, 2009). Adolescents suffering from

depression have a high risk of having a recurrent or/and continuing MDD during their adulthood, as well as impairment in various life domains such as social activities, school performances, work and interpersonal relationships. Adolescents with MDD are also at increased risk of having suicidal behavior (i.e., suicidal thoughts, suicidal attempts at or even completing suicide), as well as in developing other mental disorders such as anxiety and substance use disorders.

Several indices have been used in previous studies to follow the course and outcome of depression, such as:

1. *The episode of depression* means having the full syndrome criteria (DSM-5; The American Psychiatric Association, 2013)
2. *The remission* represents the period in which the adolescent does not show any symptoms or has minimal number of depressive symptoms (Emslie et al., as cited in Essau & Chang, 2009).
3. *The recovery* describes the period when the adolescent does not show any mental state abnormalities (Essau & Chang, 2009; Goodyer, Germany, Gowrusankur, & Altham, 1991).
4. *The relapse* describes the reappearance of a depressive episode during the remission period and before the recovery period (Emslie et al., as cited in Essau & Chang, 2009).
5. *The recurrence* represents the development of a new depressive episode that occurs after the recovery period.

8.3.1. Depressive episode among adolescents

The mean duration of MDD was between 24 to 36 weeks (Essau, 2007; Lewinsohn et al., 1994). As reported in several epidemiological and clinical setting, between 21% and 41% of children

and adolescents still suffers from depression after one year, and only 8% and 10% had depression after two years (Kovacs, Akiskal, Gatsonis, & Parrone, 1994; Lewinsohn et al., 1994). The mean length for dysthymic episode in a clinical sample is longer, up to about 3 years (Garber, Kriss, Koch, & Lindholm, 1988; Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984).

8.3.2 The remission

In a study conducted by Geller, Fox, & Clark (1994), in 83.5% of their participants, the length of major depression disorder (MDD) was almost 2 years. The average time of remission of major depression disorder since the initial evaluation was about 59.5 days (ranging from 14 to 246 days) (Emslie et al., 1997).

Factors which were associated with a longer length of index the depressive episode included being female, have an early onset (before the age of 15), severity of the episode, the presence of suicidal ideation, a dysfunctional family environment, and also receiving treatment for the mental disorder (Lewinshon et al., 1994).

8.3.3 The recovery

The rates of recovery varied across studies, possibly due to the way in which recovery is defined, as well asrelated to the length of the follow-up assessment. In a study by Garber et al. (1988), 64% of the adolescents with depression suffered from at least one episode of depression, while around 36% experienced more than one episode. In Kovacs, Gatsonis, Paulauskas, & Richards (1989), 40% of the children with depression developed a subsequent depression within 2 years. Emslie et al. (1997) reported that 98% of their participants recovered one year after their

first evaluation. However, the recurrence of MDD was high. Specifically, 47.2% and 69.4% of these adolescents reported recurrence after one and two years, respectively.

In a study by Lewinshon et al. (1994), 25% of the adolescents with MDD had recovered three weeks after their first depressive episode. Of those adolescents who recovered, around 5% experienced another episode of 6 months, only 12% experienced a recurrent episode of depression during one year and only a third started to become depressed within 4 years. the recovery rate also seemed to be related to the informants. As reported by Goodyer et al. (1991), 43% children recovered at the follow up; the recovery rate based on the report by the psychiatrists and their mothers were 50% and 53%, respectively. The author explained that differences in these recovery rates are due to the parent's inability to detect the children's cognitive and emotional symptoms.

In clinical and high-risk studies, a factor which predicted recovery was affective disorders that are present before or at the age of 13. Other predictors included being exposed to multiple parental depression, having parents who experienced high emotions, and having poor friendship after the onset of depression. Lewinsohn et al. (1994) similarly found that adolescents from community setting who suffer from MDD would need longer time to recover from their age of onset, having experienced suicidal ideation and having received treatment for other disorders. Goodyer and his colleagues (1991) reported that at a 12-month follow up investigation, none of the previous factors, including social factors (e.g., social achievement, friendship, or undesirable live events), predicted recovery for their participants. Those who had negative outcomes such as depression, reported to have a poor or moderate friendship immediately after depression was onset. Moreover, it was considered that adolescents who did not recover would report difficulties or undesirable experiences.

Another study conducted by Asarnow, Goldstein, Tompson, & Guthrie (1993) showed that adolescents whose parents had high expressed emotions were less likely to recover, compared to those whose parents reported to have low expressed emotions. At the follow up interview after one year, the participants who were from the high expressed emotion group did not recover, whereas around 53% of those who were from the low expressed emotions did recover. The authors argued that these findings were due to several socio demographic (gender, age, socioeconomic status, living arrangements) and clinical factors (e.g., treatment received during the follow-up period).

In Essau's study (2007) only 24.4% of adolescents with major depressive disorder met the diagnosis criteria at the index and the follow-up interviews. Thus, almost half of the participants (48.9%) who were previously diagnosed with MDD at the index interview no longer met the diagnostic criteria for any psychiatric illness at the follow-up interview. For the other cases, depression was replaced with other mental disorders such as substance, anxiety and somatoform disorders. The stability of depression was significantly predicted by suicidal behaviour and ideation, parental alcohol problems, the presence of substance use disorders and negative life events.

8.3.4 The relapse

Several studies have confirmed that relapse rates are high for adolescents with MDD (Asarnow et al., 1993). According to Kovacs et al. (1984), around 26% of depressed adolescents who received treatment experienced another depressive episode within one year of recovery, which for the most part led to hospital re-admittance to receive specialized treatment. In

Lewinsohn et al.'s study (1994), around half of his participants had a relapse in the first six months after initial recovery; a small number (12%) of the adolescents experienced a depressive episode after one year and approximately one third of the adolescents developed depression within a period of 4 years. In support, a previous study by Kovacs and her colleagues (1984), found that about 72% of participants were at a higher risk of relapse within a period of five years after their first episode; children who were diagnosed with "double depression" are most likely to relapse.

Length of relapse with MDD seems to be determined by the age of first onset, the presence of comorbid dysthymic disorder, a history of suicide ideation and suicidal attempt during the first MDD episode, having a more severe MDD episode (Kovacs et al., 1984; Lewinsohn et al., 1994).

Factors that predicted the recurrence of depressive disorder included distinct adolescents' features (low social skills, daily discomfort, high symptoms of depression, and the excessive emotional dependence on other people), features related to adolescent's depression (suicide attempt history, length of episode is long, the level of severity, multiple episodes) and to family mental health history (a member of the family with depression).

The overall aim of this study is to examine and compare the stability of mental health problems among adolescents from parental migrant group (LBA) and intact group. The more specific aims are to address the following research questions:

1. How stable are mental health problems within a 12-month period?
2. Which factors are associated with the stability of mental health problems?

This study aims to examine all these research questions, as well as to focus on the following hypotheses:

1) LBAs are expected to have more stable mental health problems compared to adolescents from intact families.

3) Gender, age, family factors (i.e. social support, parental bonding, parenting style), and the absence or presence of another mental illness were expected to predict the stability of mental health problems (Essau, 2007; Essau et al., 2002).

8.4. Methods

8.4.1. Design

This study is a quantitative study with a longitudinal research design, which was used to examine the course and outcomes of the most prevalent mental health problems among LBAs and adolescents from intact families, such as anxiety and depression. Moreover, the present study aims to examine the factors related to its stability.

8.4.2. Participants

Around 975 adolescents took part at the follow up, the other 781 refused to take part due to lack of time or they could not been found. Some of the participants who attended the first assessment in T1 were attending other schools at the follow up, as when they finished their 8^{th} grade they had to pass an exam, which made them choose another school from 9^{th} to 12^{th} grade. Another reason for having a decrease in number at the follow up assessment was that those

adolescents who were in the 12th grade were preparing for the Baccalaureate (EBacc), (i.e. a school performance indicator linked to the General Certificate of Secondary Education (GCSE)), and therefore they did not have the time to complete the questionnaires (Tabel 8.1.).

Table 8.1: Socio- demographic information on adolescents in Study 3- T2 (N=975) and percentages

	HAC-T2 (n=442) 45.3%	**INTACT-T2** (n=533) 54.7%	**TOTAL** (n=974) (%)
Gender			
Boys	213 (48.2)	260 (48.8)	473 (48.5)
Girls	229 (51.8)	273 (51.2)	502 (51.5)
Place of living			
Rural	138 (31.2)	141 (26.5)	279 (28.6)
Urban	304 (68.8)	392 (73.5)	696 (71.4)
Age			
14-15 years old	56 (12.7)	69 (12.9)	125 (12.8)
16-17 years old	288 (65.2)	375 (70.4)	663 (68.0)
18-18 years old	97 (21.9)	85 (15.9)	182 (18.7)
Mean (SD) 2.05 (.56)			
Parental migration & living arrangements			
No parent abroad/parent caregiver	-	513 (96.2)	-
No parent abroad/ non-parent caregiver	-	20 (3.8)	-
Mother abroad/father caregiver	131 (29.6)	-	-
Mother abroad/other caregivers	63 (14.3)	-	-
Father aboard/mother caregiver	134 (30.3)	-	-
Father abroad/other caregivers	7 (1.6)	-	-
Both parents abroad/ no caregivers	21 (4.8)	-	-
Both parents abroad/other caregivers	86 (19.5)	-	-
Caregiver type			
Parent caregiver	304 (68.8)	-	-
Grandparent(s) caregivers	77 (17.4)	-	-
Other	61 (13.8)		

8.4.3. Procedure

Similar to previous studies prior to data collection, it was necessary to obtain the approval from the University of Roehampton Ethics Board (I), as well as the approval from the Ministry of

Education (Appendix II). Regarding the recruitment procedure, please refer to Chapter 6, Section 6.4.2. This study is based on participants who took part in Study 1 and accepted, according to debrief letter, to take part in the follow-up study (Appendix VIII).

8.4.4. Instruments

In order to identify the Socio-demographic information we used the same instrument as in Study 1 (Chapter 6, Section 6.4.3.); Mental health problems were assessed using SDQ described in Chapter 6, Section 6.4.3. All measures are described in detail in Chapter 5, Section 5.3. The Alpha Cronbach has been already calculated for each instrument (see Chapter 6, Section 6.4.3, Table 6.2).

8.5. Results

8.5.1. Group differences in score changes from T1 to T2

First, changes in symptomatic scores from T1 to T2 were compared between the groups by means of repeated measures ANOVA. No significant interaction between group and time were found for SDQ total score ($F(1, 878)=0.04$, p=n.s.), emotional symptoms ($F(1, 938)=0.07$, p=n.s.), conduct problems ($F(1, 951)=0.02$, p=n.s.), hyperactivity ($F(1, 947)=0.69$, p=n.s.), peer problems ($F(1, 949)=0.18$, p=n.s.), or prosocial subscale ($F(1, 963)=1.61$, p=n.s.). Marginally significant interaction was found for SDQ impact ($F(1, 912)=2.88$, $p=0.09$); subsequent analyses using the Bonferroni method showed that while both adolescents home alone and from intact families both showed a decrease from T1 to T2, marginal difference (-=.08) indicated that

adolescents from intact homes had higher impact scores at T1, and the difference between the two groups was no longer significant at T2.

Main effect of time was shown for emotional symptoms ($F(1, 938) = 18.85$, $p < .01$) and prosocial scale ($F(1, 963) = 17.03$, $p < .01$). Regardless of the group, lower emotional symptom scores and higher prosocial skills were found at T2. In addition, main effect of group was marginally significant for emotional symptoms ($F(1, 938) = 3.01$, $p = .08$). Home alone group showed marginally higher scores than adolescents from intact families.

8.5.2. The influence of T1 social support

Incremental scores (i. e. T1 subtracted from T2) of total SDQ, emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial subscale were calculated, and correlations between these scores and social support at T1 were examined. Significant albeit weak correlations were found for both the home alone group and intact group; however, the range and impact of problems were larger in the home alone group. Specifically, peer support was related to with all factors besides conduct problems, and family support was related with SDQ total score and emotional problems in both groups. However, family support was further correlated with conduct problems, hyperactivity, peer problems, and prosocial subscale in the home alone group. Social support from significant other was not correlated with any of the scales in the intact group, whereas all of the variables excluding emotional problems showed significant correlation in the home alone group.

Table 8.2. Correlation between perceived support and SDQ

Adolescent from Intact Family	Increment Total SDQ	Increment Emotional symptoms	Increment Conduct symptoms	Increment Hyperactivity	Increment Peer problems	Increment Prosocial behavior	Increment Impact
Support - Family	.11*	.11*	.07	.08	.08	-.05	.01
Support - Friend	.87*	.19*	.004	.11	.24*	-.19*	-.02
Support – Other	.02	.02	-.01	.05	.02	-.05	-.01

Left behind adolescent	Increment Total SDQ	Increment Emotional symptoms	Increment Conduct symptoms	Increment Hyperactivity	Increment Peer problems	Increment Prosocial behavior	Increment Impact
Support - Family	.14*	.10*	.11*	.10*	.11*	-.10*	-.02
Support - Friend	.18*	.13*	.09	.13**	.17*	-.19**	.04
Support – Other	.14*	.06	.15**	.11*	.11*	-.11*	-.03

8.5.3. Correlations between symptoms and how the adolescents spend their time

Limited correlations between how the adolescents spend their free time and incremental SDQ scores emerged. For the intact group, number of hours playing computer game (r=-.09) and using the internet (r=-.11) resulted in increase in prosocial scores, and number of hours using Skype was related with decrease in peer problems (r=.12). Further, for the home alone group, number of hours using Facebook was correlated with increase in SDQ total score (r=-.15), emotional symptoms (r=-.16), conduct problems (r=-.11), and hyperactivity (r=-.12). Number of hours doing homework was related with a decrease in hyperactivity (r=.14).

8.5.4. Effects of having delinquent friends and antisocial behavior

Having delinquent friends had little or no effect on SDQ symptoms. In the intact group, having friends who smoke cigarettes was related with increase in conduct disorders (r=-.09) and a decrease in emotional symptoms (r=.09); however, the impact of the effect was fairly small. Likewise, number of friends who dropped out of school was related with an increase in hyperactivity (r=-.10), but the effect here was again quite limited. As for the home alone group, none of the correlations were significant.

Single questions regarding antisocial behaviour yielded mixed results. For both groups, fistfights or shoving matches were associated with decrease in peer problems (r=.16~.18) and increase in prosocial behaviour (r=-.15~-.13). Damaging or marking up public or private properties were associated with increase in SDQ total score (r=-.24~-.13), emotional symptoms (r=-.25~-.11), hyperactivity (r=-.13~-.08), peer problems (r=-.23~-.21), and a decrease in prosocial behaviour (r=.14~.24). Lying to teachers and skipping school was associated with heightened levels of symptomatic behaviour (i.e. SDQ total, emotional symptoms, hyperactivity, peer problems, and low prosocial behaviour; r=-.14~.25), but no significant correlations emerged for the home alone group with the exception of prosocial behaviour and skipping school (r=-.15).

8.6. Discussion

To our knowledge, the present study was the first to have examined the stability of mental health problems among life behind adolescents compared to adolescents from non-migrant parent(s). The other aim of this study was to explore factors that are associated with the stability of mental health problems in both groups of adolescents. To allow comparability with previous studies, mental health status was measured using the SDQ. These adolescents completed the SDQ and

measures related to perceived social support and adolescent's involvement in a wide range of antisocial behaviour at twice over of appropriately 12 months. A total of 975 adolescents participated in this longitudinal study; the rest (N=781) could not be contacted as they have transferred to a new school or some refused to take part due to lack of time.

The main findings could be summarized as below.

First, LBA compared to adolescents from intact family showed higher scores on emotional symptoms at T2 (i.e., approximately 12 months after the first assessment). This finding gave support to numerous previous studies (Lochhead, 2006). As shown in studies with Mexican parents migrating to the US to work, the children who were left behind with their relatives in Mexico were negatively affected in their social, psychological, and academic functioning (Lochhead, 2006). The longer the parents work in the USA, the more negative was the impact in their children; in some cases these children also had problems with school such as dropping out or having lower grades. As argued by Lochhead (2006), children left behind also represented a vulnerable group with higher risk to have psychological and behavioral problems due to of parental monitoring and constant support.

However, as discussed in chapter 2 the impact of parental migrant mixed. In some like in the present study, parental migrant seemed to have a negative impact. In some other studies, the impact is positive. For example, in the Philippines, children with migrant parents are physically healthier and emotionally better compared with children of non-migrants (Asis, 2006). It was argued that strategic long-distance parenting via regular communication and supportive family- and peer-based social environments could have contributed to the emotional well-being of left-behind children (Asis, 2006).

Second, the impact of social media and computer usage was different across groups. It is interesting to note that among LBA, more use of Facebook result in increase from T1 to T2 SDQ total score, emotional symptoms, conduct problems, and hyperactivity score. The reason for this finding is not clear. Speculatively, when support is not available from their parents or significant others, the LBAs used facebook to seek social support. The role of facebook and social media in providing support is inconsistent. In a study by Frison & Eggermont (2015) when social support was sought on Facebook and subsequently perceived, social support seeking through Facebook was associated with a decreased in adolescents' depressed mood. On the other hand, when social support was sought on Facebook, but not perceived, social support seeking through Facebook was found to increase adolescents' depressed mood. Several other authors found that Facebook is often a platform for negative behavior (e.g., Lenhart et al., 2011) and bullying (e.g., Kwan & Skoric, 2012). Furthermore, Facebook bullying seemed rather common, with 59.4% of the adolescents experienced at least one form of bullying in the past year, whereas 56.9% engaged in at least one form of Facebook bullying (Kwan & Scoric, 2012).

Among adolescents from the intact group, the number of ours spent using internet seemed to have a positive impact. Specifically, the more time they used internet and played computer game, the higher is their prosocial score. Similarly, the more they spent time on Skype, the less peer problems they have. It could be argued that among adolescents from intact family, Facebook offers a great opportunity for them to communicate with their friends within a short period of time. Furthermore, due to busy schedule to meet up with friends, bonding of friendship can be maintained through the Facebook.

Third, having delinquent friends have different impact on the two groups of adolescents. Among adolescents from intact family, having friends who smoke cigarettes was related with an increase in conduct problems. This finding is in line with previous studies that adolescent

behavior is shaped by a dynamic interaction between environmental conditions and individual characteristics that are mutually influential over time (e.g., Magnusson & Stattin 1998; Sameroff, 2010). It can be argued that having friends who smoke cigarettes could represents a risk factor associated with conduct problems, as conduct problems and cigarettes smoking often frequently comorbid (Jaccard, Blanton, & Dodge, 2005). Peers may also serve as role models, influence personal attitudes toward conduct problems (Jaccard et al., 2005).

Interestingly, among LBAs, no positive association was found between having delinquent friends and SDQ symptoms or with conduct problems. The reason for this finding is not clear, and needs to be investigated in the future.

8.7. Summary

This chapter begins by summarizing longitudinal studies on the course and outcome of emotional problem. It then describes study 3 in which approximately half of the adolescents who participated in study 1 were followed up at an average of 12 months later. Findings of this study showed that LBAs compared to adolescents from intact family showed higher scores on emotional symptoms at T2. Among LBAs, more use of Facebook result in increase from T1 to T2 SDQ total score, emotional symptoms, conduct problems, and hyperactivity score.

CHAPTER 9: MENTAL HEALTH LITERACY IN ROMANIA (STUDY 4)

9.1. Overview

As mentioned in Chapter 3, up to 30% of the adolescents in the general population have been reported to suffer from a mental disorder, with anxiety and depression being the most common (Coles & Coleman, 2010; Cruz, Duarte, Nelas, Antunes & Almeida, 2014; Hankin, 2006; Wahed & Hassan, 2017). Despite the high prevalence of mental disorders, less than one-quarter of adolescents received treatment for these disorders. One of the reasons for this underutilization of mental health services is the lack of mental health literacy.

The main aims of this chapter are to (a) describe psychology training and mental health services both during and after the communist era in Romania, (b) review literature on mental health literacy in adults and adolescents, and (c) describe and present findings of an empirical study on mental health among adults who work with young people in Romania.

9.2. Psychology during the communist era in Romania

In 1922 psychology was an independent academic program that was introduced by Florin Stefanescu Goanga, who was trained by Wilhem Wundt, at Cluj-Napoca. Immediately after this, a similar academic program was established in Iasi and Bucharest. Psychology in Romania had two sections: research institutes, which were affiliated to the "Romanian Academy of Science" and academic programs that were affiliated to universities (David, Moore & Domuta, 2002).

From 1970 to 1980, during the Ceausescu regime, psychology was forbidden as an independent academic discipline in Romania. Ceausescu was scared that psychologists might join force with the Western Spies to sabotage the state policy (Smith et al., 2004). Thus, when a group of psychologists participated in a training program on transcendental meditation technique, he accused them of holding illegal activities. Consequently, these psychologists were sent to prison, and others who escaped were sent to work in state factories. At that time Ceausescu decided to prohibit the practice of psychology and the academic psychology programs were outlawed (David et al., 2002).

After the fall of the communist regime in 1989, significant political, social and economic restructuring began in Romania, leading to the need for public services such as counselling (Szilagyi & Paredes, 2010). The academic psychology programs were re-established and after almost 11 years, the universities had independent programs for psychology. Thus, training programs in clinical psychology have only been offered in recent years (David et al., 2002).

9.2.1. Recognition of mental health services

Romania is experiencing a period of transition from communism to democracy and only recently has tried to add the community mental health care services to the traditional psychiatric system in the hospitals. There are 908 psychiatrists, out of which 260 are child psychiatrists throughout Romania (Tataru, 2005). Most of these psychiatrists work in the public health sector and some of them work in the private ambulatory clinics, as there are no private psychiatric hospitals. Romanian mental health care also includes professionals with training in social work and psychology.

The psychiatric services are provided by the hospitals and clinics that are attached to the Ministry of Health. There are 38 psychiatric hospitals and each general or day hospital has a psychiatric department that provides help for acute or chronic mental illnesses. Individuals (i.e., children, adolescents, and adults) with mental disorders can also get help from 65 mental health centers that work with the public psychiatric hospitals.

Unfortunately, the needs of people who suffer from mental disorders have not always been recognized and respected by the general health services. In August 2002 a law was passed in Romania which stated that the number of beds in the psychiatric hospitals must be reduced and, despite that, given the low number of specialists in each hospital/unit, the new regulation could not be implemented. Thus, many psychiatric wards were transferred to the social services. For example, in the county of Bihor there are now only 178 psychiatric beds (out of 900) in the Nucet Psychiatric hospital because the others were moved to the social services under the Department of Labour and Social Protection (Tataru, 2005).

Stigma continues to be an obstacle in receiving appropriate care and help for people who suffer from mental disorders, as there are still negative attitudes (even from professionals), low funding for psychiatric hospitals at both local and national level and poor quality of treatment services. However, a national mental health program is available for those who suffer from mental disorders (e.g., depression and schizophrenia), where free medication can be administered to patients (Ghodse, 2011).

9.2.2. Educational programs after the fall of the communist regime

In 1989 there were six schools of medicine in the whole country and currently there are ten. For those who study medicine, education in psychiatry lasts for six months during their last

year of their undergraduate study, which includes theoretical and practical courses in psychiatric hospitals or psychiatric departments. They are taught basic knowledge of child and adolescent psychiatry and their curriculum is based on the nosological criteria of ICD-10 and DSM-IV for the diagnosis of mental disorders. The students who wish to specialize in psychiatric program will get trained for another 5 years of postgraduate medical education, including training in psychiatric hospitals with a senior consultant psychiatrist or professor of psychiatry (Tataru, 2005).

Most of the mental health associations and societies were established after 1989 and the largest association is the Romanian Association of Psychiatry; all Romanian psychiatrists are members of this association. The other associations include the Romanian Mental Health League, the Associations of Free Psychiatrists, the Association of Geriatric Psychiatry, the Alzheimer Society, the Association of Neuro-psychopharmacology, the Association of Toxicology-Dependence, the Association of Psychotherapy, and the Association of Psychologists. The Romanian Association of Psychiatry has many projects and works with other European and international psychiatric associations in order to improve mental health services (Tataru, 2005).

9.2.3. Youth mental health services in Romania

According to a recent study by Save the Children (2011), the child rights in Romania are highly affected by the lack of an effective system for monitoring and allocating child's right implementation at the local, regional and national levels. Thus, the lack of coordination can hinder data collection and monitoring the enforcement of child's rights.

In the national public mental health sector there are around 200 child psychiatrists. In the whole country there are only 20-community health centers provided by the Ministry of Health and, therefore, most of the children with mental disorders are being treated in psychiatric hospitals, in neuro-infant psychiatric section or in other units that provide health treatments. Unfortunately, there are no evidence-based psychological programs to prevent or treat mental health problems among young people. Therefore, there is an urgent need for a better administration and development of the child' protection and integration in the health system of children and adolescents with a mental illness (Save the children, 2012; Save the children 2011).

9.3. Mental health literacy

9.3.1. Definition of Mental health literacy

A recent development in the study of mental health has been the emergence of the concept of mental health literacy which may serve to explain failure to access appropriate help. Mental health literacy refers to ‘‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al.,1997, p. 182). This concept also includes “knowledge of risk factors and causes, of self-treatments, and of professional help available, and attitudes that promote recognition and appropriate help-seeking’’ (Jorm et al., 1997, p. 182). Most studies on mental health literacy have been conducted by Jorm and his colleagues in Australia in relation to depression and schizophrenia. Several other studies have examined mental health literacy with respect to conduct disorders and personality disorders (Furnham, Hamid, 2014). Thus, our knowledge on mental health literacy is based on Australian studies.

Knowledge on mental health literacy in non-Western countries such as Romania is lacking. It is a neglected issue, particularly in rural areas where access to mental health services is

limited. Therefore, there is an urgent need to enhance mental health knowledge and awareness among communities by providing professional training on primary health care or mental health first aid (Kermode, Bowen, Arole, Pathare & Jorm, 2009). Furthermore, in order to have an effective training it is important to have evidence-based information on public knowledge regarding mental health illness.

It has been argued that understanding mental health literacy may help to alleviate difficulties in ensuring adolescents access to appropriate help with mental health issues. Studies have also indicated that mental health literacy tend to be low in low-income countries or in former Eastern European countries; studies have also indicated that low mental health literacy is related to the amount of budget located by the government for mental health services, which, in turn, influence the number of available mental health professionals. As reported by Ghodse (2011), only 2% of the allocated budget for the health system in Romania is devoted to mental health services for children, adolescents and adults. Given the low amount of budget allocated for mental health services and the number of mental health professionals for children and adolescents, mental health literacy in Romania, like in numerous other former Eastern European countries, is expected to be low (Ghodse, 2011).

9.3.2. Mental health literacy in adults

Previous studies by Jorm and his colleagues show that a high number of members of the public could not recognize mental disorders or any pathological distress. For example, a study conducted by Jorm on mental health literacy indicated that only 39 % of participants were able to label depression, while 27% of them were able to identify schizophrenia (Jorm et al., 1997; Jorm, 2000). Recent studies have reported higher recognition rates for some disorders, such as 97% for

depression, 61% for schizophrenia. These findings show an increase in mental health literacy, some authors argue that this is not due to the increase of public's awareness, but to the use of different assessment instruments (Koutoufa & Furnham, 2014). Furthermore, a recent longitudinal study provided evidence of positive changes over time regarding mental health literacy (Reavley & Jorm, 2013).

Studies on mental health literacy among mental health care workers in several developing countries have reported an urgent need to improve MHL among primary health care professionals. According to Ganasen et al. (2008), poor mental health literacy could be an obstacle in providing the appropriate treatment for those in need and this is already a concern in low- and middle-income countries where the mental health services are scarce. A study conducted by Yeo and colleagues (as cited in Ganasen, 2008) on the knowledge of mental health literacy in trained nurses who were working in a psychiatric hospital in Singapore found that the participants were largely accurate in identifying schizophrenia from the vignettes and had low accuracy in identifying depression and mania. This could be argued by the fact that schizophrenic symptoms are more distinct and perceived as abnormal, while mania and depression are largely viewed as being part of normal life experience.

Another study on mental health literacy in a Chinese general hospital similarly found that psychiatrists reported better in their ability to diagnose both schizophrenia and depression compared to registered nurses (Liu, Gerdtz, & Liu, 2011). This finding was explained by the fact that psychiatrists have the main role to diagnose, while nurses in China are seen as custodians of patients (compared to nurses in the West countries where they play the role of patient' advocates). The role of psychiatrists in Chinese hospitals involves observation, treatment and social rehabilitation.

9.3.3. Mental health literacy in adolescents

Several studies on mental literacy among youth in Australia, Sweden and Portugal reported low scores in recognizing depression, schizophrenia and psychosis. The percentages of adolescents who correctly recognize social anxiety disorder in Australia (3%-16%) and in UK (19%) were also low. In comparison, the number of youth who were able to identify social anxiety in the USA was much higher, being 28%. The same study, conducted by Olsson and Kennedy (2010), also indicated a high percentage of respondents (42%) who recognized depression as a mental disorder (as cited in Coles et al., 2016). A study conducted in Iran indicated that less than half of the adolescents were able to recognize the core symptoms of depression (Essau, Olaya, Pasha, Gilvarry, & Bray, 2013).

Previous studies have shown that the ability to recognize depression is influenced by different factors, such as age, gender and previous exposure to people who suffer from mental health disorders such as depression and anxiety (Essau et al., 2013). For example, a study in the US showed that less than 50% of the adolescents (aged 14-19) recognized depression, with girls having higher scores in MHL compared to boys for social phobia and depression vignettes (Coles et al., 2016). Other studies in the UK and Australia reported that adolescent females were more likely to recommend professional support than males (Burns & Rapee, 2006; Cotton, Whright, Harris, Jorm & McGorry, 2006; Furnham, Annis, & Cleridou, 2014; Kelly, Jorm, & Rodgers, 2006). In line with these findings, Kelly et al. (2006) found that 65% of girls were able to identify depression correctly compared to 44% of boys. The same study has shown that there were age differences, as 58% of the older adolescents were able to label depression correctly compared to 39% of the adolescents in the younger group. The recognition rates for depressive disorders have been much better recently compared to the older studies. For example, in a recent study by Yap,

Mogan, and Kyrios, (2012), 71.7% of young participants (aged 15-25) were able to identify depression correctly.

9.4. Beliefs and attitudes about mental health illnesses

Although a high number of people suffer from a mental disorder or experience a high level of mental health problems, many of them did not seek the specific treatment, partly because of public beliefs and attitudes about mental illnesses and/or their low level of mental health literacy (Jorm, Christensen, & Griffiths, 2006). According to Jorm and his colleagues (2006), the lack of appropriate recognition of disorders would lead to certain delays in seeking help or in receiving the inappropriate treatment.

Moreover, there is a gap regarding beliefs about treatment (i.e. professionals' consensus about a certain type of treatment, and public belief in these treatments), which could lead to individuals with mental disorders not receiving the recommended treatment. According to numerous studies (Jorm et al., 1997; Jorm, 2000), factors that hinder help seeking include:

A. Public stigma and discrimination (beliefs and attitudes towards people with mental health problems; Types of stigmatization;

B. Labelling people with mental illnesses (positive and negative labelling);

C. The association between help seeking and personal stigma;

9.5. Public stigma and discrimination; beliefs and attitudes towards people with mental health problems

Negative attitudes, discrimination and stereotypical attitudes towards mental illnesses have not changed dramatically in the last two decades. Numerous studies have shown that people who suffer from mental health disorders are perceived by the society as aggressive, strange, unpredictable, frightening and lacking self-control (Coppens et al., 2013; Svensson et al., 2014). As a result, people who suffer from mental illnesses have been affected in many ways by stigmatization and discrimination, by having lower self-esteem, all of which adversely affect the quality of life, as sometimes these people have difficulties in finding jobs once they have been diagnosed.

Recent studies on stigmatization towards mental health problems have generally focused on attitudes (Yoshioka, Reavley, Mackinnon & Jorm, 2014). According to this study, stigmatizing attitudes towards people with mental health problems are more common in adolescents which may cause several difficulties; this, in turn, could make them feel socially disconnected, dependent on others or even feel abnormal. Thus, adolescents who suffer from mental health illnesses are less likely to seek professional help as they have difficulties in coping with stigmatizing attitudes. According to Macsinga (2011), if the public beliefs and attitudes towards people who suffer from mental disorders do not change over time, they might experience serious problems with integration and could become the target of social rejection. Therefore, they tend to be more reluctant to seek professional help.

Recently, in developing countries, there is an emerging need for people to increase their knowledge regarding mental health (Jorm, Christensen, & Griffiths, 2006). Therefore, in most of these countries mental health literacy has improved, as well as attitudes towards people who

suffer from mental health problems. The findings from several studies conducted in USA, Australia and Germany have shown a decrease in the gap between mental health professionals' and public beliefs about causes and treatment of mental health disorders; the willingness to seek professional help has increased as the public were more able to recognize mental disorders (Angermeyer, Holzinger, & Matschinger, 2009).

Taken together, findings of studies (Dietrich et al., 2004; Dietrich, Matschinger & Angermeyer, 2006) that examined the public's attitudes and beliefs towards people who suffer from mental illness can be summarized as follows:

- the majority of public are not able to identify certain mental illnesses;
- psychological stress was considered to be the most often mentioned factor that leads to mental disorders;
- most of the participants believed that those who suffer from mental illnesses are in need of professional help as they are considered to be dangerous and unpredictable;
- there is a stronger tendency of social rejection of alcohol and drug consumption compared to that of people who suffer from depression and anxiety;
- most studies have focused on public's attitudes towards those who suffer from depression and schizophrenia, whereas studies on other disorders have been neglected.

9.6 Labeling people with mental illnesses (positive and negative labeling)

Recent studies have focused on labelling theory and its modification, as well as the one associated with stigma related to mental health problems (Jorm, 2000). Findings have shown that there is a negative and stigmatizing impact on the person who suffers from a mental disorder, and

has been labelled as mentally ill. Other studies have highlighted that public use of psychiatric terms to label mental disorder problems that can lead to stigmatization. Thus, according to Link and Phelan (2010), (as cited in Wright, Jorm & Mackinnon, 2011) there are both negative and positive aspects regarding labelling a person with mental health problems, which can be seen as a "package deal". However, it was concluded that labelling the person with mental health problems is stigmatizing, while labelling the problem itself could be beneficial for the person, as it helps to facilitate treatment that will ameliorate the symptoms. Therefore, a clear distinction between labelling the person and the problem would encourage the person to recognize the problem and seek professional help (Wright et al., 2011).

Several studies have focused on various types of stigma (Wright et al. 2011):

- personal stigma (i.e., stigmatizing attitudes a person may have regarding others);
- self-stigma (i.e., stigmatizing views the person has regarding themselves);
- perceived stigma (i.e., related to beliefs regarding stigmatizing views that other people may have);
- interpersonal stigma (i.e., occurs within interpersonal communication where the person has the experience of being stigmatized; discriminatory behaviors and structural discrimination, when the policies of private institutions have opportunity restrictions towards people with mental disorders).

9.7. Research questions and hypothesis

The lack of professionals who deliver mental health services to adolescents with mental health problems in Romania means that most adolescents with these problems are seen by NGOs and other end-users (e.g., teachers). However little is known about their knowledge regarding their mental health literacy. Therefore, to make up, for this gap, the main aim of this study was to identify the level of mental health literacy among professionals who work with LBAs (e.g., NGOs, teachers, those working in youth justice system). The specific aims of this study are to address the following questions:

- What percentage of the adult participants (professional/non-professionals) in Romania is able to recognize symptoms of common mental health problems (i.e. depression, depression and alcohol consumption, depression and suicide ideation, separation anxiety and generalized anxiety) among young people? What do adult participants believe is helpful in treating and preventing these mental health problems?
- Do specialists and non-specialists differ in their ability to accurately label these mental health problems?
- What types of treatments do Romanian specialists and non-specialists believe to be helpful for mental health problems?
- What do participants believe are the causes of depression and the other mental health disorders?
- What are predictors of correct recognition of youth mental health problems?

The hypotheses to be explored in this study are:

(1) In line with previous studies in low-income countries, a low percentage of participants in Romania are able to correctly identify the symptoms of common mental health problems among young people.

(2) Mental health specialists (e.g., social workers, psychologists, SENCO) are expected to be able to accurately label the disorders portrayed in the vignette.

(3) Participants (i.e. specialists and non-specialists) are expected to consider vitamins as the most helpful treatment for mental health problems.

(4) Participants are expected to consider receiving counselling as beneficial for adolescents with mental health problems.

(5) Participants are expected to consider having parent(s) who work abroad as a common cause of youth mental health problems.

(6) Adult's personal level of psychological distress (i.e., depression, anxiety and stress level) is expected to be associated with the ability to recognize signs of mental health problems.

9.8. Methods

9.8.1. Participants

The sample consisted of 250 participants (17.6% were males and 82.4% were females), who had been recruited from several public institutions from Iasi and the surrounding areas. They ranged in age from 22 to 63 (M= 40.19, SD= 8.57). A high percentage of participants were from the urban areas 92.7% and only 7.6% were from the rural areas (Table 9.1). In terms of

occupation, most of them were teachers/parents, followed by SENCO and social workers.

Table 9.1. Socio-demographic characteristics of professionals and non-professionals

	N	%
Gender		
Males	44	17.6
Females	206	82.4
Age		
<39 years	109	47.6
>39 years	120	52.4
Mean (*SD*) 40.19 (8.57)		
Occupation		
Social worker	51	20.4
Psychologist	32	12.8
School Psychologist	40	16.0
Teacher and parents	61	24.4
Psycho-pedagogy	12	4.8
SENCO	54	21.6
Region of living		
Rural	19	7.6
Urban	230	92.4

9.8.2. Procedure

Participants were recruited from 4 public institutions (Child Welfare and Schools with special services – DGSAPJ, School Psychologist Association - CJRAE, two high schools) in Romania, Moldova area. The public institutions were from the city of Iasi and from two small cities near Iasi (Tg. Frumos and Pascani) making the sample representative for the mental health professionals who work with adolescents who suffer from mental health problems. The

participants were randomly recruited from these institutions after the approval to recruit from these institutions was obtained from the relevant Directors/Managers (Appendix XI).

The data collection started after an ethical approval was obtained from the University of Roehampton Ethics Board (Appendix I), and from the Ministry of Education and Culture represented by School Inspectorates who are affiliated to School Psychologists Association in Romania (Appendix XI).

All participants were informed about the purpose of the present study and design. Once they agreed to take part in the study, the participants were given a consent form to sign (Appendix VII). Participants were asked to create their own code, which consists of the first letter of their first name and surname and the month of their birth (e.g., Alina Dafinoiu whose month of birth is March will have this code: AD03). This code will be written on their consent form, completed questionnaires, and debrief form.

The questionnaires were administered by the researcher in a designated room within each institution and the participants were allowed to ask any questions that they might have. The questionnaires were answered anonymously. A debrief form (Appendix VIII) was given to the participants at the end of the study. The participants had the right to withdraw at any time.

9.9. Mental Health Literacy questionnaire

The **Mental Health Literacy questionnaire** (Jorm et al., 1997) was used to measure the participants' level of knowledge about specific mental health problems. Respondents were randomly administered one of the 5 vignettes: depression, depression with suicidal ideation,

depression with alcohol misuse, social phobia, and general anxiety disorder. The vignette comprised a male and female version. Respondents were randomly administered one of the 5 vignettes describing a person of their own gender. Thirty-eight participants received the vignette with symptoms of “depression”, 55 participants received the vignette with “depression and alcohol consumption”, 54 with “alcohol and suicide ideation”, 46 with “social phobia”, and 57 received the vignette with generalized anxiety.

In order to adapt the questionnaire to Romanian adolescents, the names in the 5 vignettes *(see Appendix XIV.1, XIV.2, XIV.3, XIV.4, XIV.5)* were changed to common Romanian names. “John” was changed to “Ion” and “Mary” to “Maria”. These vignettes were used to assess: (a) Recognition of the specific mental health problem; (b) Beliefs about prompted first actions; (c) Beliefs about types of help; (d) Beliefs about preventative strategies for the specific mental health problem; (e) Beliefs about likely causes of mental health problem; (f) Exposure to the mental health problem.

Recognition of the specific mental health disorders: To measure whether or not the participants could recognize and assess knowledge of the disorder shown in the vignettes, they were asked to answer an open-ended question: “What, if anything, do you think is wrong with Ion/Maria?”.

The answers were considered to be correct if the participant answered: “depression”, “depression and alcohol consumption”, “depression and suicide ideation”, “social phobia”, “generalized anxiety” based on the vignette. Their answers were classified as “other”, if they did not give the answers above. The answer “other” was coded into six categories: communication problems, psychological problems (e.g., anxious, worried), sick, behaviour problems related to puberty, love problems (e.g., breaking up, conflict) and "I do not know".

Beliefs about prompted first actions: The participants were asked about their beliefs regarding the first action that the young people would take to get help: "There are a number of different things a friend or family member could do that could possibly help Ion/Maria with his/her problem". They were asked to rate the things which a friend or family member would do for the person described in the vignette, whether they considered them to be *helpful, harmful or neither*: listen to his/her problem in an understanding way, talk to him/her firmly about getting him/her act together, suggest he/she seek professional help, make an appointment for him/her to GP, psychotherapy or bioenergy-therapist, ask him/her whether he /she feels suicidal, suggest him/her have few drinks to forget the troubles, rally friends to cheer him/her up, ignore him/her until he/she gets over it, keep him/her busy to keep his/her mind off problems, and encourage him/her to become more physically active.

Beliefs about types of help: The respondents were asked to rate a series of questions about whether or not they considered the various interventions described in each vignette as "helpful", "harmful" or "neither". The list of interventions the vignette included: a wide range of professionals (GP or family doctors, teacher, counsellor, telephone counsellor, psychologist, psychiatrist, cognitive therapist, close family members, close friend, on his own), medications (i.e. vitamins, St Jon's Wort, antidepressant, tranquillizers, antipsychotic, sleeping pills), and various psychological treatments (e.g., getting relaxation training, practising meditation, receiving counselling, receiving cognitive behaviour therapy, getting acupuncture), and several lifestyle interventions (e.g., using alcohol to relax, smoking cigarettes, using marijuana to relax, cutting down on use of alcohol, cutting down on smoking cigarettes, cutting down on marijuana). In addition to the list of professionals who are believed to help, professionals who are common

and specific to Romania were added. These included: bioenergy-therapist, priests, ericksonian therapist, gestalt therapist, somatic therapist, transactional therapist, and experiential therapist.

Beliefs about preventative strategies for the specific mental health problem: The participants were asked to answer the following question: "If a young person like Ion/Maria did the following, do you think it would reduce their risk of developing a problem?" The preventive strategies were: keeping physically active, avoiding situations that might be stressful, keeping regular contact with his/her friends, keeping regular contact with school psychologist, keeping regular contact with family, having his both parents at home, avoiding sugary food, not using marijuana, never drinking alcohol, making regular time for relaxing activities, having a religious or spiritual belief. They were asked whether the actions presented above were "helpful", "harmful", "neither", "depends", "don't know".

Beliefs about likely causes of mental health problem were assessed by asking the participants to rate the factors which might have caused Ion/Maria's situation: bad character, brain disease, the way he/she was raised, stress, a genetic or inherited problem, God's will, bad luck, a curse, the school schedule, too many exams and homework at school, the normal ups-and-downs of life, a mental illness, being teased by his/her peers at school because the parents are overseas, a physical illness. Some items that are specific to the situations in Romania were added: his parent migration (mother, father), his both parents migration, to take care of his/her siblings as his parents were abroad. Most of the items had been adapted from Jorm et al. (1997) and several causes were added according to the Romanian context. The participants were asked to rate their responses using the following answers: "very likely", "somewhat likely", "not very likely", "not at all likely".

Exposure to the mental health problem was examined by asking participants if they had experienced a similar problem presented in the vignette in the last 12 months, or if they had a close friend or a family member who had the same problem as Ion/Maria. Each item was rated "yes", "no" or "don't know" and included questions such as: "Has anyone in your family or close circle friends ever had a problem similar to Ion's/Maria's?"

The Depression, Anxiety, and Stress Scale (Lovibond & Lovibon, 1995) (DASS) was used to assess current symptoms of depression, anxiety, and stress. The depression subscale (7 items) consisted of items related to dysphoric mood, hopelessness, and lack of interest. The anxiety subscale (7 items) included symptoms of autonomic arousal and fearfulness, and anxiety symptoms. The stress subscale (7 items) included symptoms related to tension and a tendency to overact to stressful events. Respondents indicated how much the statements applied to them over the past week, using a 4-point Likert scale ranging from 0 (did not apply to me) to 3 (applied to me very much or most of the time). Scores for depression, anxiety, and stress were calculated by summing scores for the relevant items.

The Mental Health Knowledge Schedule (Evans-Lacko et al., 2010) (MAKS) was used to measure six stigma-related mental health knowledge areas: help-seeking, recognition, support, employment, treatment, and recovery and 6 items which inquire about knowledge of mental illness conditions. MAKS items were scored on an ordinal scale, ranging from "strongly agreed" (5) to strongly disagreed (1). The total score for each participant was calculated by adding together the response values of each item. "Don't know" was coded as neutral (3) for the purposes of determining a total score.

9.10. Results

9.10.1. Recognition of the mental disorder

Table 9.2 presents coded answers of the respondents to the open-ended question, "What if anything, do you think is wrong with Ion/Maria?" based on the type of the vignette they were given (i.e. depression, depression and alcohol, depression and suicide ideation, social phobia and generalized anxiety). The results indicate that less than half of the participants for each group were able to provide the right label to each of the vignette. The most common answer reported by participants was "psychological problems", 21.1% out of those who received depression vignette, 11.3 % depression and suicide ideation and 20.4 % for generalized anxiety. The least common answers were "sick", 1.9% out of those who received generalized anxiety vignette as well as for the other ones, "love problems", 2.6% for those who received depression vignette and 1.9% for generalized anxiety vignette. The participants were more likely to indicate that the person described in the vignette was having "communication problems", 10.5% respondents who got depression vignette and 29.5% for social phobia. However, there were high percentages of respondents who were not able to indicate the right label for each vignette, such as: depression (18.4%), depression and alcohol consumption (11.1%), depression with suicide ideation (20.8), social phobia (18.2%) and generalized anxiety (16.7%).

The next step of the analyses was to examine whether or not there were any differences among participants in recognizing the symptoms of specific disorders. For this purpose, the participant's ages were categorized into two age groups (based on the mean age): one age group consisted of those below the age of 39, and another age group consisted of those 40 and above. Further analysis indicates that there were age differences between the two groups regarding labelling each vignette (Table 9.3.). The participants from the younger group (<39 years old)

were significantly better at recognizing the labels used to describe the person from the four vignettes than those from the older group (>39 years old). The older participants had higher scores in recognizing generalized anxiety compared to the younger ones.

Table 9.2. Percentages of respondents mentioning each category to describe the problem shown in the vignette

Category mentioned	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety
Depression/Anxiety/ Social phobia	12 (31.6)	18 (33.3)	21 (39.6)	6 (13.6)	20 (37.0)
Communication problems	4 (10.5)	4 (7.4)	2 (3.8)	13(29.)	4 (7.4)
Psychological problems	8 (21.1)	4 (7.4)	6 (11.3)	9 (20.5)	11 (20.4)
Sick	2 (5.3)	3 (5.6)	0	0	1 (1.9)
Behavior problems (puberty)	4 (10.5)	1 (1.9)	3 (5.7)	2 (4.5)	3 (5.6)
Love problems	1 (2.6)	4 (7.4)	0	0	1 (1.9)
I don’t know	7 (18.4)	6 (11.1)	11 (20.8)	8 (18.2)	9 (16.7)
Alcohol	0	9 (16.7)	2 (3.8)	0	0
Depression and anxiety	0	0	3 (5.7)	0	5 (9.3)

Table 9.3. Percentages of respondents who answered correctly to each of the vignette

	Participants who were 39 years and younger N (%)	Participants who were 40 years and older N (%)
Depression	7 (46.7)	4 (19.0)
Depression and alcohol problem	11 (57.9)	10 (32.3)
Depression and suicide ideation	17 (56.6)	9 (45.0)
Social phobia	7 (33.3)	5 (25.0)
Generalized anxiety	6 (28.6)	8 (32.0)

* Age group <39; ** Age group >39. Results in bold indicate significant differences between the two age groups.

Beliefs about prompted first actions

Most participants considered "listen to his/her problems in an understanding way" (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), as the best help for Ion/ Maria's problem (90.4%). Other types of help which were considered as helpful, included "Suggest seeking professional help" (79.2%) and "Make an appointment for psychotherapy" (64.6%). Having a family member or friends suggest Ion/Maria "have few drinks to forget his/her trouble" was seen the least helpful thing to do when dealing with a problem (1.6%).

Beliefs about types of help and treatments

The majority of respondents considered psychologists as being the most helpful person to deal with Ion's/Maria's problem (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), and having mother's/father's support and counsellor's help. Psychiatrists were regarded as the least helpful.

Across all vignettes, the type of all medicine that could help Ion/Maria overcome his/her problem (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), vitamins were considered to be the most helpful, followed by St John's wort and antidepressants. Antipsychotics and tranquilizers were reported as the least helpful.

Appendix (XIV.1; XIV.2; XIV.3; XIV.4; XIV.5) shows the activities that might help Ion/Maria overcome his/her problem. Receiving counselling (90.8%) and joining a support group (82.4%) were the most commonly endorsed activities that could help the person described in the vignette. Activities such as using alcohol (3.2%) and smoking cigarettes (2.4%) were advocated to be least helpful for Ion's/Maria's problem.

Activities that were considered (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5) helpful in preventing the illness included “keeping regular contact with family” (94.8%) and “making regular time for relaxing activities” (93.6%). The least helpful preventative activities were “discussing his/her problem on Facebook" (10.3%) and “avoiding sugary foods” (13.3%).

Appendix (XIV.1; XIV.2; XIV.3; XIV.4; XIV.5) describes personal stigma attitudes of respondents towards the person described in the vignette. Almost half of participants considered that “she/he could snap out if she/he wanted” (41.4%) whereas the lease commonly identified stigmatizing attitudes were that the person should be avoided “so you don’t develop the same problem” (2.8%). Regarding public stigma (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5) the majority of the participants believed that Ion's/Maria’s problem “is a sign of personal weakness” (56.4%) and “if they wanted they could snap out of it” (57.2%). A small percentage of those believed he/she is “dangerous” (20.5%), and that "it is the best to avoid him/her so you do not develop the same problem” (20.0%).

Regarding stigmatizing attitudes towards the person described in the vignette (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), more than half of the participants who received the vignette with generalized anxiety (56.8%) were willing to “go out with Ion/Maria at the weekend”, compared to only 18.6% of those who received the vignette with depression and suicide ideation.

The most common endorsed cause was “his/her both parents migrated” (97.2%) and “staying at home alone because his/her parents are working abroad” (97.1%), whereas the least identified causes were “bad luck” (4.0%) and “God will” (12.6%), (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5).

9.10.2 Mental health literacy: Professional versus non-professional

The next step of our analysis was to compare mental health literacy between professionals and non-professionals. Overall, results showed that professionals and non-professionals did not differ significantly in first-aid intention (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), types of help that are considered as helpful in helping the vignette (e.g., teacher, priest) (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5), and types of medicine (Appendix XIV.1; XIV.2; XIV.3; XIV.4; XIV.5).

Regarding activities that might help the person described in the vignette (Appendix ….), two of the most frequently reported beneficial activities were "joining a support group" and "receiving counselling". Activities that were considered least helpful were "using alcohol", "smoking cigarettes" and "using marijuana to relax".

9.11. Predictors of mental health literacy

To analyze the predictors of mental health literacy (i.e., correct labelling of the vignette), a multilevel logistic regression using the vignette disorder as a level factor was used. Significant predictors were (Table 9.4): age, having anyone from their family/close friends with a similar disorder, participant's anxiety and stress.

Specifically, the younger participants and participants with family members with mental disorders and those with higher anxiety and lower stress symptoms are better able to recognize the vignettes.

Table 9.4: Summary of logistic regressions predicting correct labeling of vignette

	Odds ratio	95% CI	
(Intercept)	0.145	0.039	0.405
Age	0.938	0.888	0.987
Depression vignette	1.094	0.349	4.250
Anxiety vignette	0.116	0.015	0.669
MAKS	0.990	0.909	1.084
Depression	1.084	0.853	1.372
Anxiety	0.726	0.520	0.979
Stress	1.398	1.021	1.920

Note: Random effect variance < .01

9.12. Discussion

Due to historical events, Romania lacks professionals who are specifically trained to deliver evidence-based treatment among young people with mental health problems. This means that these young people are mostly seen by NGOs and non-mental health professionals – whose mental health literacy is not known. Therefore, to make up for this gap, the main aim of the present study was to identify the level of mental health literacy among professionals who work with children and adolescents, including left behind adolescents (LBAs) (e.g., NGOs, teachers, those working in youth justice system).

Results showed that almost half of the participants were not able to recognize the five vignettes correctly. Of all the five vignettes, the respondents who received the vignette on depression with suicide ideation and generalized anxiety reported the highest percentages for correctly labelling the disorders portrayed in the vignette. Findings from previous studies conducted in Western-industrialized countries like in Australia (Jorm & Wright, 2008) and the US (Cole et al., 2011) have shown higher percentages of those who correctly labelled the disorders described in the vignette.

The reasons for these different findings could be related to the amount of resources available in mental health services in different countries. As argued by Ghodse (2011), in Romania, only 2% of the budget for health services in Romania is allocated for the mental health services. Given this low amount of resources, the number of professionals who could work to promote mental health literacy is also low. Furthermore, as discussed previously, psychology is a "relatively" new discipline in Romania as it was prohibited during the communist regime, and it was only since 1989 that psychology could be reestablished (David et al., 2002). It is only in recent years that universities have begun to train students to be clinical psychologists and psychotherapists (David et al, 2002). Thus, the number of professionals who are trained in clinical psychology and/or evidence-based treatment is not surprisingly much lower than those in developed countries.

Furthermore, the low recognition rate of mental disorders among the participants may be related to the "experience" of the participants themselves; specifically, many of the participants are in the forties and fifties – meaning that they were raised during the communist era when talking about mental health issues were frowned upon or not talked about openly (David et al., 2002). In relation to this, it is worth noting that there is an age difference in the ability to recognize symptoms of mental disorders. Many studies conducted in Western countries have shown adolescents to have a higher recognition rate for depression (Essau et al., 2013; Farrer, Leach, Griffiths, Christensen, & Jorm, 2008).

Previous studies have shown that the participants were more likely to indicate that the person described in the vignette had fallen in love and this could be the cause of their problem (Essau et al., 2013). However, in the present study the respondents were more likely to indicate that Ion/Maria had communication and psychological problems. The reason for this inconsistent finding

is unclear. However, it is worth noting that the study by Essau et al. (2013) was conducted in Iran and that all the adolescents are brought up in an Islamic way in which open expression of love among single adolescents of opposite sex is forbidden.

A direct comparison with other studies may not be appropriate, as there is a big age difference between the participants from this study who were much older, 22-63, compared to Australian or Iranian studies and according to previous findings, age was related to the ability to identify the right label. The findings from this study showed that significantly younger participants (under 39) compared to older ones (above 39) correctly labelled depression and anxiety. In a study that examined adolescents' mental health literacy, Essau et al. (2013) showed that more participants who were from the older group could identify depression more easily compared to younger participants.

It is interesting to note that almost all participants were more likely to believe that listening to Ion's/Maria's problem was helpful and was considered the most beneficial prompted first action (90.4%), followed by suggesting him/her seeking professional help. In contrast, findings from other studies identified that younger participants believeed that ignoring the problem or distracting the person was helpful in dealing with depression (Essau et al., 2013; Jorm, Wright, & Morgan, 2007; Yap et al., 2012).

In terms of types of help and treatment, participants were more likely to consider that talking with one member of the family was as helpful as a counsel's help for the person described in the vignette. This was an important finding which deserves to be commented on. In Romania, traditional norms and values persist in terms of views on the parent’s role. According to Romanian principles, family plays an important role in youth development similarly to other cultures, and

parental bonding seems to be highly important. Adolescents are encouraged since they are young to let their parents know everything that happens to them, so that they could get the support needed. However, according to our study, the level of knowledge among non-professionals was low and therefore it can be argued that there is a need to target the non-professionals to improve their mental health first aid and helping skills. These Romanian traditional values and norms could also be used to explain for the difference in first action found in the present study.

Several participants believe that antidepressants are helpful for the problem described in the vignettes. According to the National Institute for Health and Clinical Excellence (NICE, 2005), antidepressants are not recommended as a first line of treatment of adolescents, even if they are suffering from moderate or severe depression, unless they are combined with current psychological therapy. Moreover, cognitive behavioral therapy, as well as short term therapy, is recommended for these adolescents as a first line treatment (NICE, 2005). Similarly to NICE recommendation regarding professional support and Essau et al. (2013) findings, our study showed a high number of respondents considered that receiving counselling is the most beneficial activity for Ion's/Maria's problem. It could be argued that Romanian's preference for counselling and supportive group maybe related to the fact that these services are highly integrated in mental health services and in the wider society in Romania.

In terms of preventing strategies that participants reported as helpful for depression and anxiety, the present study had similar findings to those reported by Essau et al. (2013) and Yap et al. (2012). Specifically, most commonly, the strategies that were identified included: regular contact with family and friends, relaxing activities and keeping contact with the school psychologist. The only difference from Essau et al. (2013) was in relation to high endorsement of

"keeping regular contact with friends", which almost all respondents (82.0 %) endorsed compared to 56.6% in Essau study (2013).

Our findings also indicated that young age, having family members with mental disorders, and having high level of anxiety symptoms were significant predictors of the ability to recognize the vignettes. The finding that age had a role in mental health literacy replicated previous finding in that younger compared to older participants were more accurate at identifying symptoms of mental disorders, described more sources of treatment as helpful and are less likely to stigmatize mental illness (Fisher & Goldney, 2003; Reavley et al., 2013). Our finding that having family members with mental health problems was associated with better mental health literacy was in line with previous studies. For example, in a study by Piper, Bailey, Lam, and Kneebone (2018), adults who were in close proximity to someone with a mental disorder demonstrated better total mental health literacy, and better mental health literacy regarding depression and social phobia. This finding was not surprising because a close proximity to an individual with mental health problems may reduce existing stigmas, and enable education about mental disorders regarding symptoms and appropriate treatments. Our finding also showed high level of anxiety symptoms to significantly predicted the ability to recognize the vignettes; this might be related to the participant's familiarity with anxiety symptoms and information related to their treatment.

To conclude, given the high prevalence of mental health problems among people in Romania, it is important that more training in evidence-based treatment for youth mental health be offered in this country.

9.12. Summary

This chapter describes a historical account regarding the establishment of psychology in Romania both during and after the fall of the communist regime. Our review on the provision of

mental health services in Romania, particularly among adolescents is very low. Findings of this study showed low mental health literacy among adults (N=250) who work with young people. Specifically, less than half of the participants were able to provide the right label to the vignettes. Predictors of the ability to recognize the vignettes included young age, having family members with mental disorders, and having high level of anxiety symptoms.

CHAPTER 10: GENERAL DISCUSSION

10.1. Overview

The final chapter of this thesis brings together the findings from Studies 1-4 and reviews the contribution of these studies in advancing the understanding of youth mental health. Strengths and limitations of these four studies and the implications of findings, in relation to prevention of mental health problems are then discussed. This chapter ends by considering future research in this area.

10.2. Results' summary

Adolescence is the period when several mental health problems occur (Costello et al., 2004; Essau, et al., 2000; Essau & Ollendick, 2013; Merinkangas et al., 2010). Consistent with previous studies, the findings of the present research showed a high percentage of Romanian adolescents are suffering from mental health problems. The high rate of mental health problems found in the present study replicated previous studies; in previous studies, prevalence rates ranging from 4.8% to 42% have been reported in Denmark (Elberling, Linneberg, Olsen, Goodman, & Skovgaard, 2010), Ireland (Greally et al., 2009; 2010), India (Banerjee, Bhat & Chatterjee, 2015), Iran (Alavi, Mohammadi, Joshaghani, & Mahmoudi-Gharaei, 2010; Arman et al., 2012). The most common are symptoms of dysthymia and social phobia.

Significantly more girls than boys reported symptoms of dysthymia and social phobia. These results are in line with previous findings that reported that girls had higher prevalence rates of anxiety symptoms compared to boys (Duchesne & Ratelle, 2016; Essau et al., 2012; Essau et al., 2014; Salk, Petersen, Abramson & Hyde, 2016). It was argued that these gender differences may be related to hormonal changes and the way they respond to stress; the latter suggests that girls tend to become more sensitive and pay more attention to their emotions than boys (Cyranowski et al., 2000; Essau, 2010, 2014; Hankin et al., 2007).

The prevalence of mental health problems differ across age. Specifically, older adolescents (i.e., 17-18 years old) have higher scores on ADHD, Dysthymia and Specific phobia, compared to younger adolescents (13-16 years old).

Results on age differences revealed that both girls and boys aged between 15 to 16 years reported higher prevalence rates for almost all mental health problems compared to the other two age groups (i.e. 13 to 14 and 17 to 18). These findings are in line with previous studies, which found that the older compared to younger adolescents reported higher scores for both emotional and behavioral problems (Essau et al., 2014). Interestingly, some of our findings were not in line with previous results, as some studies have reported the younger age groups are more likely to suffer from hyperactivity compared to the older age groups (Arman et al., 2012; Mohammdi et al., 2014; Slobodskaya et al., 2007). A possible reason for the age differences on mental health problems could be associated with school transition (Nielsen et al., 2017). In Romania, the school transition refers to age group 15 to 16, when the children are changing schools, moving from Junior to Senior High School. In support, Nielsen and colleagues (2017) state that those children who are experiencing these transitions are at higher risk to suffer from different mental health problems. Another reason for

these age differences is due to the transition from childhood to adulthood (Johnson & Wolke, 2013). This transition is a period of rapid growth that is related to major social, physical and emotional changes; indeed, studies have reported this period to be linked to the onset of several mental health problems (Costello et al., 2003; Ford et al., 2003; Kessler et al., 2005). Other factors that predicted mental health problems social support and parental styles Our findings are in accordance with previous studies which reported that inconsistent parenting was associated with emotional, and behaviour problems (Jaekel, Leyendecker & Agache, 2016). In support, Stadler et al. (2010) stated that a quality relationship between parent(s) and adolescents would reduce the risk for developing mental health problems. Moreover, regarding parental bonding, adolescents having overprotective parents are at a great risk to develop several mental health problems (Canetti et al., 1997; Indumathy & Ashwini, 2017; Ngai et al., 2013). However, the impact of parental overprotection differs across cultures. As reported by Chao (1994) in Asian culture, overprotective parents have a positive impact on their children's and adolescents' outcomes.

Results from Study 2 revealed that the highest number of adolescents have their mother working abroad. In line with previous studies, it was found that the number of left behind children with both parents working abroad was smaller compared to those who have only one migrant parent (Robila, 2010; G. Toth, A. Toth, Voicu, & Ştefănescu, 2007). It was found that those LBAs with migrant mothers were at a higher risk for developing mental health problems compared to those who were left behind by their fathers. This finding gave support to previous findings that the gender of the migrant parent has a significant impact on a child's psychological outcomes (Hu et al., 2014; Toth et al., 2007; Vanore, 2015; Wen & Lin, 2012).

The study on mental health literacy indicated that a high percentage of adults who work with adolescents failed to correctly label the vignettes. The fact that these adults have limited mental health literacy is of concerned given the high number of adolescents with mental health problems. The low level of mental health literacy might have been linked with historical reasons. As stated in chapter 9, psychology was prohibited during the communist regime, and it was only since 1989 that psychology could be re-established (David et al., 2002), and thus psychology is a "relatively" new discipline in Romania. Therefore, it is not surprising that the number of people trained in providing evidence-based intervention is much lower than those in other European countries. Furthermore, the budget allocation for mental health services is only 2% for all the mental health services in Romania (Ghose, 2011); of these 2%, the allocation for youth mental health is unknown. With little economic resources, the number of professionals who should promote mental health literacy is relatively low.

10.3. Strengths and limitations

The four studies that make up this thesis have several strengths that should be acknowledged. First, the studies cover a wide range of mental health problems and their correlates in two groups of adolescents (i.e., those from intact families and adolescents with migrant parent). This research adds to the body of literature which highlight the high prevalence of mental health problems among adolescents in general and among adolescents with migrant parent(s) in specific.

Second, this research was conducted in a country where there is a lack of research in youth mental health. Thus, the present findings make an original and unique

contribution to the field of clinical adolescent psychology. In particular, the results could help to raise awareness on the high prevalence of mental health problems among adolescents, particularly among those with parental migrant at the national level. At the policy makers' perspective, the findings could be used to allocate budget and services to address the considerable rates of youth mental health. Third, in addition to using a cross-sectional approach, one of the studies used a longitudinal approach to study the stability of mental health problems within a 12-month period and examined factors that predict their stability.

The present findings need to be considered in the context of the limitations associated with this thesis. First, the data were based only on the adolescents' self–report. Self-report measures offer pragmatic tool for data collection from large numbers of participants within the constraints of school settings. Teachers or parents should be included as informants, however, these informants may not be the best individuals to provide information about the adolescents as they are less aware of adolescent's mental health problems particularly those related to internalizing problems (Essau & Barett, 2001; Hu, Lu & Huang, 2014). Second, adolescent's mental health problems were based on the cut-offs score of the SDQ and Youth Inventory 4R. Future studies should consider using an in-depth clinical interview to measure mental health problems. Third, adolescents were recruited from schools and did not include those who are who were absent from school. Furthermore, the specific focus of this thesis is on adolescents with migrant parent(s). It did not include the internal migration (i.e., rural to urban areas) within Romania. As such they might not be representative of all the adolescents in Romania, but they may provide an important initial look into the effects of parental migration mental health on

adolescents in Romania. Finally, although one of the four studies used a longitudinal approach to examine the stability of mental health problems; examining causal inferences and interrelationships was outside the scope of this study. The present study followed up the adolescents within a one-year period. Following these adolescents into young adulthood would provide information about the long term impact of parental migration.

10.4. Implication of the Findings

Despite these limitations, the results obtained could have clinical and training implications. These fall in three key areas.

10.4.1. Implications for parents

According to Bronfenbrenner's bioecological system theory, the adolescent's development can be understood within the context of relationships in their environment (Bronfenbrenner, 2005). Parents are significant figures in adolescents' microsystem (Bronfenbrenner, 2005). Adolescence is the transition period from childhood to adulthood, which is associated with significant changes on the physical, emotional and cognitive levels (Crone & Dahl, 2012); these changes are linked with intense emotions. Furthermore, the adaptational capacities of adolescents are often put into test (Urdan & Midgley, 2003), as they navigate these transitions (Simmons & Blyth, 1987). Indeed, numerous studies have shown adolescence as a critical period of time in terms of emotional and behavioural problems, declines in self-esteem, and risk for delinquent behaviours (Baker, Grant, & Morlock, 2008). It is therefore not surprising that adolescence is often regarded as a period of "storm and stress".

Therefore, during the adolescence it is important that parents support, supervise and monitor their behaviour, and teach the adolescents the skills they need to enhance their competence to face challenges. Thus, parents should consider the psychological impact of their absence (i.e., as a result of working abroad) on their children who they leave behind in Romania.

10.4.2. Implications for adolescent health policy and training

Given the high prevalence of mental health problems in Romania, evidence-based prevention/intervention programme for preventing mental health problems among adolescents are urgently needed in Romania. In order to make it sustainable, it is important that a critical mass of professionals who work with children and adolescents be trained and equipped with some of the strategies that the adolescents need to overcome stress-provoking situations. Such strategies could be manualised and professionals could be trained using the train-the-trainer model. One such evidence-based prevention programme is Super Skills for Life (SSL; Essau & Ollendick, 2013) programme. SSL is a trans-diagnostic treatment protocol for children and adolescents with emotional problems (Essau et al., 2014). SSL has five core principles: (1) it targets common core risk factors (e.g., low self-esteem, lack of social skills) of comorbid disorders, and as such it should be more time efficient and cost-effective (Rohde, 2012); (2) it is based on the principles of Cognitive Behavior Therapy to help children and adolescents develop skills to cope with anxiety-provoking situations; (3) it uses video feedback with cognitive preparation to help children enhance their self-perception (Harvey et al., 2000); (4) it uses the principle of behavioural activation by having children increase their activity levels and participate

in positive and rewarding activities, which in turn can help to improve their mood and overall self-esteem; (5) finally, it teaches children basic skills to use during social interactions to help increase their experience of successful outcomes from the interactions.

In addition to the children/adolescent's workbook, SSL also has a facilitator's manual that gives step-by-step instructions on how to deliver each sessions of this programme. As such SSL is widely used in many low- and middle-income countries, and is being implemented by various government departments world-wide. SSL has proven to be effective in reducing emotional problems among school children when delivered by researchers and by school services staff (i.e., non-psychologist) (Essau et al., 2019).

In relation of the findings of the present study, it would be useful to adapt SSL for adolescents in Romania in general and specifically for adolescents with parental migrant.

10.4.3. Mental health literacy campaign

Our finding demonstrated that mental health literacy for anxiety and depression among adults who work with adolescents is very poor. This finding is important because it suggested that adolescents who have mental health problems are seen by adults with limited knowledge in recognizing anxiety ad depressive symptoms, and about evidence-based prevention and intervention. As shown in numerous studies, lack of mental health literacy is significantly associated with stigmatization which in turn is related to lack of help seeking behaviour (Jorm et al.,

2006). The results emphasizes the need for campaigns to increase knowledge about anxiety and depressive disorders, particularly the presence of comorbid disorders. Past interventions to improve mental health literacy have been successful, with campaigns increasing literacy levels and leading to improved help seeking (Jorm, 2000).

APPENDICES

Appendix I: Ethical Approval for Study 1, Study 2 & Study 3

Dear Alina,

Ethics Application
Applicant: **Alina Dafinoiu**
Title: **Psychological wellbeing of "home alone" adolescents in Romania**
Reference: **PSYC 13/ 109**
Department: **Psychology**

Many thanks for your response and the amended documents. I am pleased to confirm that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 13/ 109 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 16.01.14

Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison
Ethics Officer - Research Office, Academic Enhancement Department
University of Roehampton | Froebel College | Roehampton Lane | London | SW15 5PJ

jan.harrison@roehampton.ac.uk| www.roehampton.ac.uk
Tel: +44(0)20 8392 5785
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Join our circle on Google+ | Connect via LinkedIn

Appendix II: Ethical Approval from Ministry of Education and Culture (Study 1, 2 & 3)

University of Roehampton London

ETHICS COMMITTEE

LETTER AND CONSENT FOR SCHOOL INSPECTORATES

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Dear School Inspectorate,

I am a researcher based in the Department of Psychology, University of Roehampton in London. I am conducting a large project, which aims to examine the impact of parental employment abroad on their children's well-being, under the supervision of Professor Cecilia Essau. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: The participants will complete a set of questionnaires in a designated room (a classroom) in their school.

Phase 2: The second phase of the study will examine the extent to which adolescents' family situations, views towards school, and social activities may have changed over the next 12 months.

The participants will be asked to complete a set of questionnaires, which will take a total of about 40 minutes to complete. These questionnaires will be used to assess: (i) family structure, (ii) well-being, (iii) the type of perceived support they get from their family, (iv) their social activities, and (v) their school achievement.

I will administer the questionnaires to the participants to ensure confidential and independent responding, in a designated room (a classroom) in their school. I have been Disclosure and Barring Service (DBS) checked.
Only adolescents who gave their consent and who also have a parental written consent will be allowed to participate in the present study.

All responses will be anonymous and confidential. No identifying details will be recorded on the questionnaire. Participants' name and other identifying information will be kept securely and separately from the rest of the questionnaire. Only my supervisory team members and I will have access to the data.

If you are happy to support this research by allowing us to meet with school Principals, I would be most grateful if you could confirm this by signing the provided consent slip below.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet you to discuss this further.

Yours sincerely,
Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Consent Form

I have seen and approved all the instruments to be used in this study. I agree for the schools from Iasi to take part in the study (Project's title: The impact of parental migration on adolescents' well-being in Romania).

School Inspectorate: _____

Signature: _____

Date: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 3627

Appendix III: Ethical Approval from School Psychologists Association (Study 1, 2 & 3)

University of Roehampton London

ETHICS COMMITTEE

LETTER AND CONSENT FOR SCHOOL PSYCHOLOGISTS ASSOCIATION (CJRAE)

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Dear School Inspectorate,

I am a researcher based in the Department of Psychology, University of Roehampton in London. I am conducting a large project, which aims to examine the impact of parental employment abroad on their children's well-being, under the supervision of Professor Cecilia Essau. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: The participants will complete a set of questionnaires in a designated room (a classroom) in their school.

Phase 2: The second phase of the study will examine the extent to which adolescents' family situations, views towards school, and social activities may have changed over the next 12 months.

The participants will be asked to complete a set of questionnaires, which will take a total of about 40 minutes to complete. These questionnaires will be used to assess: (i) family structure, (ii) well-being, (iii) the type of perceived support they get from their family, (iv) their social activities, and (v) their school achievement.

I will administer the questionnaires to the participants to ensure confidential and independent responding, in a designated room (a classroom) in their school. I have been Disclosure and Barring Service (DBS) checked.
Only adolescents who gave their consent and who also have a parental written consent will be allowed to participate in the present study.

All responses will be anonymous and confidential. No identifying details will be recorded on the questionnaire. Participants' name and other identifying information will be kept securely and separately from the rest of the questionnaire. Only my supervisory team members and I will have access to the data.

If you are happy to support this research by allowing us to meet with schools Principals, I would be most grateful if you could confirm this by signing the provided consent slip below.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet you to discuss this further.

Yours sincerely,

Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Consent Form

I have seen and approved all the instruments to be used in this study. I agree for the schools from Iasi to take part in the study (Project's title: The impact of parental migration on adolescents' well-being in Romania).

School Inspectorate: _____

Signature: _____

Date: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 3627

Appendix IV: Invitation Letter for Head Teacher of School (Study 1, 2 & 3)

University of Roehampton London

ETHICS COMMITTEE

LETTER AND CONSENT FOR THE HEAD TEACHERS OF SCHOOL

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Dear Head Teacher,

I am a researcher based at the Department of Psychology, University of Roehampton in London. I am conducting a large project, which aims to examine the impact of parental employment abroad on their children's well-being, under the supervision of Professor Cecilia Essau. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: The participants will complete a set of questionnaires in a designated room (a classroom) in their school.

Phase 2: The second phase of the study will examine the extent to which adolescents' family situations, views towards school, and social activities may have changed over the next 12 months.

To achieve this aim, the adolescents will be asked to complete a set of questionnaires, which will take a total of about 40 minutes to complete. These questionnaires will be used to assess: (i) family structure, (ii) well-being, (iii) the type of perceived support they get from their family, (iv) their social activities, and (v) their school achievement.

I will administer the questionnaires to the participants to ensure confidential and independent responding, in a designated room (a classroom) in their school. I have been Disclosure and Barring Service (DBS) checked.
Only adolescents who gave their consent and who also have a parental written consent will be allowed to participate in the present study.

All responses will be anonymous and confidential. No identifying details will be recorded on the questionnaire. Participants' name and other identifying information will be kept securely and separately from the rest of the questionnaire. Only the researchers will have access to the data.

If you are happy to support this research by allowing me/us to recruit adolescents from your school, I would be most grateful if you could confirm this by signing the provided consent slip below. The day and time of the research will be agreed on in advance with you, in order not to interrupt any lessons.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet you to discuss this further.

Yours sincerely,
Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Consent Form

I have seen and approved with the instruments to be used in this study. I agree for the adolescents in my class to take part in the study (Project's title: The impact of parental migration on adolescents' well-being in Romania).

Head Teacher: _____

Signature: _____

Date: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 36

Appendix V: Ethical Approval from Principal (Study 1, 2 & 3)

University of Roehampton London

ETHICS COMMITTEE

LETTER AND CONSENT FOR THE SCHOOL PRINCIPAL

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Dear School Principal,

I am a researcher based at the Department of Psychology, University of Roehampton in London. I am conducting a large project, which aims to examine the impact of parental employment abroad on their children's well-being, under the supervision of Professor Cecilia Essau. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: The participants will complete a set of questionnaires in a designated room (a classroom) in their school.

Phase 2: The second phase of the study will examine the extent to which adolescents' family situations, views towards school, and social activities may have changed over the next 12 months.

To achieve this aim, the adolescents will be asked to complete a set of questionnaires, which will take a total of about 40 minutes to complete. These questionnaires will be used to assess: (i) family structure, (ii) well-being, (iii) the type of perceived support they get from their family, (iv) their social activities, and (v) their school achievement.

I will administer the questionnaires to the participants to ensure confidential and independent responding, in a designated room (a classroom) in their school. I have been Disclosure and Barring Service (DBS) checked.

Only adolescents who gave their consent and who also have a parental written consent will be allowed to participate in the present study.

All responses will be anonymous and confidential. No identifying details will be recorded on the questionnaire. Participants' name and other identifying information will be kept securely and separately from the rest of the questionnaire. Only the researchers will have access to the data.

If you are happy to support this research by allowing to recruit adolescents from your school, I would be most grateful if you could confirm this by signing the provided consent slip below. The day and time of the research will be agreed on in advance with you, in order not to interrupt any lessons.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet you to discuss this further.

Yours sincerely,

Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Consent Form

I have seen and approved with the instruments to be used in this study. I agree for the adolescents in my school to take part in the study (Project's title: The impact of parental migration on adolescents' well-being in Romania).

School Principal: _____

Signature: _____

Date: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 3627

Appendix VI: Letter and Consent Form for Parents (Study 1, 2 & 3)

University of Roehampton London

ETHICS BOARD

LETTER AND CONSENT FOR PARENTS

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Dear Parent/Guardian,

I am a researcher based at the Department of Psychology, University of Roehampton in London. I am conducting a large project, which aims to examine the impact of parental employment abroad on their children's well-being, under the supervision of Professor Cecilia Essau. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: The participants will complete a set of questionnaires in a designated room (a classroom) in their school.

Phase 2: The second phase of the study will examine the extent to which adolescents' family situations, views towards school, and social activities may have changed over the next 12 months.

To achieve this aim, the adolescents will be asked to complete a set of questionnaires, which will take a total of about 40 minutes to complete. These questionnaires will be used to assess: (i) family structure, (ii) well-being, (iii) the type of perceived support they get from their family, (iv) their social activities, and (v) their school achievement.

I will administer the questionnaires to the participants to ensure confidential and independent responding, in a designated room (a classroom) in their school. I have been Disclosure and Barring Service (DBS) checked.
Only adolescents who gave their consent and who also have a parental written consent will be allowed to participate in the present study.

All responses will be anonymous and confidential. No identifying details will be recorded on the questionnaire. Your child's name and other identifying information will be kept securely and separately from the rest of the questionnaire. Only the researchers will have access to the data.

If you are happy to support this research by allowing your child to participate in our research, I would be most grateful if you could confirm this by signing the provided consent slip below.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet you to discuss this further.

Yours sincerely,

Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Parental Consent Form

I agree for my child to take part in the study (Project's title: The impact of parental migration on adolescents' well-being in Romania).

Parent: _____

Signature: _____

Date: _____

Child's name: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel:0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 3627

Appendix VII: Participant Consent Form (Study 1, 2 & 3)

University of Roehampton London

Participant ID number:

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Brief Description of Research Project:

The main aim to this study is to examine how young people feel about their parent who are working abroad, and the impact that parental employment abroad has on their children's well-being. For this purpose, you will be asked to complete a set of questionnaires, which will take about 40 minutes. This study consists of 2 phases that will be conducted in Iași (Romania).

Phase 1: You are kindly asked to complete a set of questionnaires in a designated room (a classroom) in your school.

Phase 2: The second phase of the study will examine changes in your family situations, your views towards school, and social activities may have changed over the next 12 months.

Consent for you to participate in the present study will also be obtained from your parents.

The questionnaires that you will complete are used to measure various aspects of your family situations, your views towards school, and about your social activities.

The questionnaires will also be kept confidential and only be used for research purposes. Signed consent form will be kept separately from all other data.

In order for us to be able to contact you for the second phase of this study, please write you contact information below:

Mobile number: _____

E-mail address: _____

The questionnaires will also be kept confidential and only be used for research purposes. Only the researcher and her supervisory team will know the true identity of the participant, accessible through a personal code.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Psychology (or if the researcher is a student you can also contact the Director of Studies).

Investigator:

Alina Dafinoiu
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Director of Studies

Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0044208392 3647

Head of Psychology

Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 004420 8392 3627

Consent Statement:

- I agree to participate in this project.
- I understand that all personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).
- I understand that the information which I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings.
- I am aware that I am free to withdraw at any point.
- I agree that the data will be stored in a secure location for at least 10 years.
- I agree to disclose my name and to be contacted for the second part of this research.

Name ……

Signature ……..

Mobile number: ……

E-mail: ……

Date ……

Appendix VIII: Participant Debrief Letter (Study 1, 2 & 3)

Participant ID number:

ETHICS COMMITTEE
PARTICIPANT DEBRIEF LETTER

Title of Research Project: The impact of parental migration on adolescents' well-being in Romania

Thank you very much for taking part in this study, we greatly appreciate your contribution.

This study was conducted to examine the impact of parental migration on the way you feel about life in general, your social activities, and academic achievement.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw from the study, contact us with your participant number (above) and your information will be deleted from our files. Please be aware, however, that data in summary form may already have been used for publication at the time of request.

If you are troubled or worried about any aspects of the study, or issues it may have raised, please feel free to contact any of the following agencies:

1) Asociatia Alternative Sociale
   Tel: 0332 405 476
   E-mail: office@alternativesociale.ro

2) Soros Foundation Romania
   Tel: 021 212 1101/02
   E-mail: info@soros.ro

3) Salvati copiii (Save the children)
   Tel: 0742 061 917
   E-mail: iasi@salvaticopiii.ro

Should you have a concern about any aspect of your participation in this study, please raise this with me. Alternatively, you may like to take up your concerns with the Head of the Department of Psychology (or if the researcher is a student you can also contact the Director of Studies).

Investigator:

Alina Dafinoiu
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk
Tel: 0040723467316

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk

Tel: 0044208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk

Tel: 004420 8392 3627

Appendix IX.1: Social and Health Assessment (Study 1, 2 & 3)

Participant ID number:

University of Roehampton London

SAHA

2. How many of your friends…		None of Them	A Few of Them	Some of Them	Most or All of them
a.	smoke cigarettes on a pretty regular basis?	**1**	**2**	**3**	**4**
b.	have dropped out of school before finishing high school?	**1**	**2**	**3**	**4**
c.	go out in the evening without their parents' permission?	**1**	**2**	**3**	**4**
d.	drink alcohol fairly regularly?	**1**	**2**	**3**	**4**
e.	use marijuana, amphetamine or any other drug?	**1**	**2**	**3**	**4**
f.	have had sexual intercourse? (Think of friends the same sex as you.)	**1**	**2**	**3**	**4**
g.	have been at the juvenile court because of their behavior?	**1**	**2**	**3**	**4**
h.	have skipped school a lot without permission?	**1**	**2**	**3**	**4**
i.	have been arrested by the police?	**1**	**2**	**3**	**4**

3. The next questions are about your background.

a. How old are you? **10** **11** **12** **13** **14** **15** **16** **17** **18**

b. What sex are you? **Male** **Female**

c. What grade are you in? **6th** **7th** **8th** **9th** **10th** **11th** **12th**

4. Have you ever stayed back or repeated a grade in school? **No** **Yes, once** **Yes, more than once**

We would like to begin by asking you about yourself and the different types of school and community activities you do.

How many people are living in this home now (including yourself)?

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10 or more**

How many of these are 17 years old or younger? **0** **1** **2** **3** **4** **5** **6 or more**

How many are adults, that is 18 years old or older? **0** **1** **2** **3** **4** **5** **6 or more**

Circle below who these adults are.

Mother	**Father**	**Grandmother**	**Grandfather**	**Foster mother**	**Foster father**
Stepmother	**Stepfather**	**Aunt**	**Uncle**	**Other female adults**	**Other male adults**

6. Who is working abroad from your family?
(Please circle the answer.)

Mother **Father** **Both**

7. How long they have been away?

6 months **1 year** **More than 1 year**

8. How often do you communicate with them?

Every day **1 time/week** **2-3 times/week** **Each 2 weeks** **Each 3 weeks**

1. How many hours on a regular school day do you spend:	None	½ Hr	1 Hr	2 Hrs	3-4 Hr	5+ Hrs
a. doing homework?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
b. watching TV?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
c. reading books, magazines, or newspapers?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
d. playing computer/video games?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
e. using the Internet?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
f. using Facebook?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**

g.	using Skype?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
f.	taking care of brothers or sisters?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
h.	at home without an adult?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**
i.	playing/hanging out in the neighborhood?	**0**	**1/2**	**1**	**2**	**3-4**	**5+**

11. ***My parents/guardian/tutor…***	Never	Rarely	Sometimes	Often
a. ask me about my life.	**1**	**2**	**3**	**4**
b. tell me what time to be home when I go out.	**1**	**2**	**3**	**4**
c. forget a rule they have made.	**1**	**2**	**3**	**4**
d. are kind to me.	**1**	**2**	**3**	**4**
e. spend time on activities at my school.	**1**	**2**	**3**	**4**
f. want to know who I am meeting with.	**1**	**2**	**3**	**4**
g. make me ask permission when I go out in the evening.	**1**	**2**	**3**	**4**
h. spend their free time with me.	**1**	**2**	**3**	**4**
i. nag me about little things.	**1**	**2**	**3**	**4**
j. want to know if I've gotten my homework done.	**1**	**2**	**3**	**4**
k. hug or kiss me.	**1**	**2**	**3**	**4**
l. encourage me to be interested in different things.	**1**	**2**	**3**	**4**
m. correct me when they don't like how I behave.	**1**	**2**	**3**	**4**
n. only keep rules when it suits them.	**1**	**2**	**3**	**4**
o. are proud of me.	**1**	**2**	**3**	**4**
p. give me good advice.	**1**	**2**	**3**	**4**
q. make sure I don't smoke.	**1**	**2**	**3**	**4**
r. threaten punishment more often than they use it.	**1**	**2**	**3**	**4**
s. show their love for me.	**1**	**2**	**3**	**4**
t. are interested in my friends.	**1**	**2**	**3**	**4**
u. tell me what I can watch on TV.	**1**	**2**	**3**	**4**

v.	enforce a rule or do not enforce a rule depending upon their mood.	**1**	**2**	**3**	**4**
w.	make me feel good when I am with them.	**1**	**2**	**3**	**4**
x.	*make sure I don't drink alcohol.*	**1**	**2**	**3**	**4**

5. Think about the home you live in most of the time.

9. How do you communicate with them?

Phone **Skype** **Facebook**

10. How often do they send you money?

Every month **Each 2-3 months** **Each 6 months** **Never**

For the next questions, answer for both of your parents or guardians or the parent or guardian that is most important in raising you.

12.	I feel safe in my home.	**Definitely Not True**	**Mostly Not True**	**Mostly True**	**Definitely True**

The next questions ask about experiences some people have had.

		0 Times	1 Time	2 Times	3-4 Times	5 or More Times
13.	During the **past year**, how many times have they:					
a.	started a fistfight or shoving match?	**0**	**1**	**2**	**3-4**	**5+**
b.	shoplifted from a store?	**0**	**1**	**2**	**3-4**	**5+**
c.	damaged or marked up public or private property?	**0**	**1**	**2**	**3-4**	**5+**
d.	lied to a teacher to cover up something you did?	**0**	**1**	**2**	**3-4**	**5+**
e.	stayed out all night without permission?	**0**	**1**	**2**	**3-4**	**5+**
f.	lied to your parents or guardians about where you have been or who you were with?	**0**	**1**	**2**	**3-4**	**5+**

g.	skipped school without permission?	**0**	**1**	**2**	**3-4**	**5+**
h.	hurt someone badly in a physical fight so that they had to be treated by a doctor or nurse?	**0**	**1**	**2**	**3-4**	**5+**
i.	carried a gun?	**0**	**1**	**2**	**3-4**	**5+**
j.	been involved in gang fights?	**0**	**1**	**2**	**3-4**	**5+**
k.	been arrested by the police?	**0**	**1**	**2**	**3-4**	**5+**
l.	seen someone get shot or stabbed?	**0**	**1**	**2**	**3-4**	**5+**
m.	carried a blade, knife, or gun in school?	**0**	**1**	**2**	**3-4**	**5+**
n.	been suspended from school?	**0**	**1**	**2**	**3-4**	**5+**
o.	been <u>at school</u> after drinking alcohol?	**0**	**1**	**2**	**3-4**	**5+**
p.	been high <u>at school</u> from smoking marijuana?	**0**	**1**	**2**	**3-4**	**5+**
q.	stolen a motorcycle or car?	**0**	**1**	**2**	**3-4**	**5+**
r.	pick-pocketed somebody?	**0**	**1**	**2**	**3-4**	**5+**
s.	sold drugs to earn money?	**0**	**1**	**2**	**3-4**	**5+**
t.	been in juvenile court because of your behavior?	**0**	**1**	**2**	**3-4**	**5+**

Appendix IX.2: Youth Inventory 4R (Study 1, 2 & 3)

Participant ID number:

APPENDIX 2

YOUTH'S INVENTORY – 4R (YI-4R)

	Never	Some-times	Often	Very often
A1. I make careless mistakes.	0	1	2	3
A2. I have trouble paying attention.	0	1	2	3
A3. I have trouble following directions.	0	1	2	3
A4. I start things but do not finish them.	0	1	2	3
A5. I have trouble getting organized.	0	1	2	3
A6. I try to avoid doing things that require a lot of concentration like schoolwork and homework.	0	1	2	3
A7. I lose things.	0	1	2	3
A8. Other things going on easily distract me.	0	1	2	3
A9. I am forgetful .	0	1	2	3
A10. I am fidgety.	0	1	2	3
A11.I have trouble sitting still.	0	1	2	3
A12. I feel restless and jittery**.**	0	1	2	3
A13. I have trouble doing things quietly.	0	1	2	3
A14. I am a person who is "on the go".	0	1	2	3
A15. People say that I talk too much.	0	1	2	3
A16. I blurt out the answers to questions before I hear the entire question.	0	1	2	3
A17. I get frustrated when I have to wait my turn to do things.	0	1	2	3
A18. I interrupt others or butt into other people's business.	0	1	2	3

Ax. How often do the behaviors in Group A make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group B	**Never**	**Some-times**	**Often**	**Very often**
B19. I skip school.	0	1	2	3
B20. I stay out at night when I am not supposed to.	0	1	2	3
B21. I lie to get my own way and to get out of doing things.	0	1	2	3
B22. I threaten to hurt people.	0	1	2	3
B23. I start physical fights..	0	1	2	3
B24. I run away from home overnight.	0	1	2	3
B25. I take things when other people are not looking.	0	1	2	3
B26. I destroy other peoples' property.	0	1	2	3
B27. I set fires.	0	1	2	3
B28. I force people to give me their money or things.	0	1	2	3
B29.I break into houses, buildings, or cars.	0	1	2	3
B30. I use a weapon when I fight (bat, bottle, knife, etc.)	0	1	2	3
B31. I try to hurt animals.	0	1	2	3
B32. I try to physically hurt people.	0	1	2	3
Bx. How often do the behaviors in Group B make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group C	**Never**	**Some-times**	**Often**	**Very often**
C39. I lose my temper.	0	1	2	3
C40. I argue with adults.	0	1	2	3
C41. I don't do what adults tell me to do.	0	1	2	3
C42. I try to do things to annoy people.	0	1	2	3
C43. I blame others for my own mistakes.	0	1	2	3
C44. Other people annoy me.	0	1	2	3
C45. I get angry.	0	1	2	3
C46. When I get angry, I take it out on others.	0	1	2	3

Cx. How often do the behaviors in Group C make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group D	**Never**	**Some-times**	**Often**	**Very often**
D47. I worry a lot.	0	1	2	3
D48. I have trouble getting myself to stop worrying.	0	1	2	3
D49. I feel nervous.	0	1	2	3
D50. I feel grouchy or cranky.	0	1	2	3
D51. I get real tense and can't relax.	0	1	2	3
D52. I have trouble falling asleep or staying asleep.	0	1	2	3
Dx. How often do the behaviors in Group D make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group E	**Never**	**Some-times**	**Often**	**Very often**
E53. I am very afraid of certain things like animals, heights, storms, going places alone, or being "trapped".	0	1	2	3
E54. There are times when my heart pounds a lot and I feel dizzy and shaky and have difficulty breathing.	0	1	2	3
E63. I get real nervous in social situations.	0	1	2	3
E64. I am really shy when I am around other kids my age.	0	1	2	3
Ex. How often do the behaviors in Group E make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group G	**Never**	**Some-times**	**Often**	**Very often**
G65. I get very upset when I have to leave home.	0	1	2	3
G66. I worry that my parents will be hurt or leave home and not come back.	0	1	2	3
G68. I try to avoid going to school in order to stay home with my parent.	0	1	2	3
G69. I worry about being left at home alone.	0	1	2	3

G71. I have nightmares about being left alone.	0	1	2	3
Gx. How often do the behaviors in Group G make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group K	**Never**	**Some-times**	**Often**	**Very often**
K84. I feel unhappy or sad.	0	1	2	3
K85. I don't feel like doing anything.	0	1	2	3
K86. I think about death or suicide.	0	1	2	3
K87. I don't like myself.	0	1	2	3
K88. I feel tired, like I don't have any energy to do things.	0	1	2	3
K89. I feel bad that I can't do things as well as other people.	0	1	2	3
K90. I feel that things never work out right.	0	1	2	3
K91. I eat a lot.	0	1	2	3
K92. I sleep a lot.	0	1	2	3
K96. My feelings get hurt very easily.	0	1	2	3
Kx. How often do the behaviors in Group K make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Group M and L	**Never**	**Some-times**	**Often**	**Very often**
M108. I skip meals and eat very little.	0	1	2	3
L103. I have trouble concentrating	0	1	2	3

Group O	**Never**	**Some-times**	**Often**	**Very often**
O115. I smoke tobacco cigarettes.	0	1	2	3
O116. I drink alcohol beverage (beer, wine, liquor).	0	1	2	3
O117. I get into trouble because of alcohol use.	0	1	2	3

O118. I tried to smoke marijuana.	0	1	2	3
O119. I use other illegal drugs (cocaine, glue, speed, LSD, Ecstasy, Ethno-botanic).	0	1	2	3
O120. I get into trouble because of illegal drug use.	0	1	2	3
Ox. How often do the behaviors in Group O make it harder to do schoolwork, get along with others, or work on a job?	0	1	2	3

Appendix IX.3: Strength and difficulties Questionnaire

(Study 1, 2 & 3)

Participant ID number:

SDQ

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			

I finish the work I'm doing. My attention is good			

	No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
Overall, do you think that you have difficulties in one or more of the following areas: Emotions, concentration, behaviour or being able to get on with other people?				

If you answered 'YES', please answer the following questions about these difficulties:

How long have these difficulties been present?

□ Less than a month □ 1-5 months
□ 6-12 months □ Over a year

Do the difficulties upset or distress you?

□ Not at all □ Only a little
□ Quite a lot □ A great deal

Do the difficulties interfere with your everyday life in the following areas?

- Home Life □ Not at all □ Only a little □ Quite a lot □ A great deal
- Friendships □ Not at all □ Only a little □ Quite a lot □ A great deal
- Classroom Learning □ Not at all □ Only a little □ Quite a lot □ A great deal
- Leisure Activities □ Not at all □ Only a little □ Quite a lot □ A great deal

Do the difficulties make it harder for those around you (family, friends, teachers etc.)?

□ Not at all □ Only a little □ Quite a lot □ A great deal

Appendix IX.4: Perceived Social Support (Study 1, 2 & 3)

Participant ID number:

PERCEIVED SOCIAL SUPPORT ASSESSMENT

SOCIAL SUPPORT ASSESSMENT

PSS

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	6	5	6	7

1.There is a special person who is around when I am in need. 1 2 3 4 5 6 7

2. There is a special person with whom I can share my joys and sorrows. 1 2 3 4 5 6 7

3. My family really tries to help me. 1 2 3 4 5 6 7

4. I get the emotional help and support I need from my family. 1 2 3 4 5 6 7

5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 7

6. My friends really try to help me. 1 2 3 4 5 6 7

7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7

8. I can talk about my problems with my family. 1 2 3 4 5 6 7

9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 7

10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7

11. My family is willing to help me make decisions. 1 2 3 4 5 6 7

12. I can talk about my problems with my friends. 1 2 3 4 5 6 7

Appendix IX.5: Parental Bonding Instrument (Study 1, 2 & 3)

University of Roehampton London

Participant ID number:

APPENDIX 5

PARENTAL BONDING INSTRUMENT (PBI)

MOTHER FORM

This questionnaire lists various attitudes and behaviors of parents. As you remember your MOTHER in your first 16 years would you place a tick in the most appropriate box next to each question?

	Very Like	Moderately Like	Moderately unlike	Very Unlike
1. Spoke to me in a warm and friendly voice				
2. Did not help me as much as I needed				
3. Let me do those things I liked doing				
4. Seemed emotionally cold to me				
5. Appeared to understand my problems and worries				
6. Was affectionate to me				
7. Liked me to make my own decisions				
8. Did not want me to grow up				
9. Tried to control everything I did				
10. Invaded my privacy				
11. Enjoyed talking things over with me				
12. Frequently smiled at me				
13. Tended to baby me				
14. Did not seem to understand what I needed or wanted				
15. Let me decide things for myself				
16. Made me feel I wasn't wanted				

17. Could make me feel better when I was upset				
18. Did not talk with me very much				
19. Tried to make me feel dependent of her/him.				
20. Felt I could not look after myself unlesss he/he was around				
21. Gave me as much freedom as I wanted				
22. Let me go out as often as I wanted				
23. Was overprotective of me				
24.Did not praise me				
25. Let me dress in any way I pleased				

FATHER FORM

This questionnaire lists various attitudes and behaviours of parents. As you remember your FATHER in your first 16 years would you place a tick in the most appropriate box next to each question

	Very Like	Moderatel y Like	Moderatel y unlike	Very Unlike
1. Spoke to me in a warm and friendly voice				
2. Did not help me as much as I needed				
3. Let me do those things I liked doing				
4. Seemed emotionally cold to me				
5. Appeared to understand my problems and worries				
6. Was affectionate to me				
7. Liked me to make my own decisions				
8. Did not want me to grow up				
9. Tried to control everything I did				
10. Invaded my privacy				
11. Enjoyed talking things over with me				
12. Frequently smiled at me				

13. Tended to baby me				
14. Did not seem to understand what I needed or wanted				
15. Let me decide things for myself				
16. Made me feel I wasn't wanted				
17. Could make me feel better when I was upset				
18. Did not talk with me very much				
19. Tried to make me feel dependent of her/him.				
20. Felt I could not look after myself unlesss he/he was around				
21. Gave me as much freedom as I wanted				
22. Let me go out as often as I wanted				
23. Was overprotective of me				
24.Did not praise me				
25. Let me dress in any way I pleased				

Appendix X: Ethical Approval for Study 4

Dear Alina,

Ethics Application
Applicant: **Alina Dafinoiu**
Title: **Knowledge of youth mental health in Romania**
Romania
Reference: **PSYC 14/ 120**
Department: **Psychology**

Many thanks for your response and the amended documents. Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 14/ 120 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 04.04.14.

Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison
Ethics Officer, Research Office, Academic Enhancement Department
University of Roehampton | London | SW15 5PJ
jan.harrison@roehampton.ac.uk| www.roehampton.ac.uk
Tel: +44 (0) 20 8392 5785
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Appendix XI: Letter for Institutions (Study 4)

University of Roehampton London

ETHICS BOARD

LETTER FOR INSTITUTIONS

Title of Research Project: Knowledge of youth mental health in Romania

Dear Head of the Institution/ Manager,

I am a researcher based in the Department of Psychology, Roehampton University in London. I am conducting a large project, which aims to examine the levels of mental health literacy, among adults in Romania, under the supervision of Professor Cecilia Essau.
To achieve this aim, the participants will be administered with a set of questionnaires that describes a vignette of an adolescent with a common mental health problem such as depression. They will be asked the extent to which they are able to recognize that mental health problem, its treatment and preventative strategies, and its possible cause.

I will administer the questionnaires to the participants to ensure confidential and independent responding. I have been Criminal Records Bureau (CRB) checked.

Only participants who have signed consent forms to participate in the present study will be allowed to take part in the project.

If you are happy to support this research by allowing us to meet with your employees, I would be most grateful if you could confirm this by signing the provided consent slip below.

If you have any questions, please feel free to contact me. If you prefer, I would be more than happy to come in and meet with you to discuss this further. I look forward to hearing from

Yours sincerely,
Alina Dafinoiu
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk

Examples of questions that will be used in this project

John is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.

1. What, if anything, do you think is wrong with John?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like John, would you ask him to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask him to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother

☐ Would seek help from father

☐ Would seek help from other person (specify): _____

☐ Would seek help from service (specify): _____

☐ Don't know

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for John's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Consent Form

I agree for the adolescents in my school to take part in the study (Project's title: Mental health problems among "home alone" adolescents in Romania) and I understand that they have the right to withdraw from the study at any time.

Director of Institution/Manager: _____

Signature: _____

Date: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Department or the Director of Studies.

Director of Studies
Professor Cecilia Essau
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0208392 3647

Head of Psychology
Dr Diane Bray
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 020 8392 3627

Appendix XII: Participant Consent Form (Study4)

Participant ID number:

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project: Knowledge of youth mental health in Romania

Brief Description of Research Project:

The main aim to this study is to examine the levels of mental health literacy, among adults in Romania. For this purpose, you will be asked to complete a set of questionnaires, which will take about 30 minutes to complete. The questionnaire describes a vignette of an adolescent with a common mental health problem. You will be asked to label that mental health problem, its treatment and preventative strategies, and its possible cause.

The questionnaire will be completed anonymously. The questionnaire will also be kept confidential and only be used for research purposes. Signed consent form will be kept separately from all other data.

The second part of the study will involve attending a 1-day workshop on mental health aid, which is to be delivered by Prof Essau. The third part of this study will examine the course and outcome of mental health literacy.

In order for us to be able to contact you for the second and third parts of this study, please write you contact information below:

Mobile number: _____

E-mail address: _____

The data will be protected and only the researcher will know the true identity of the participant, accessible through a personal code. The questionnaires will also be kept confidential and only be used for research purposes.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Head of Psychology or my Director of Studies.

Investigator:

Alina Dafinoiu
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk

Director of Studies

Professor Cecilia Essau
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk
Tel: 0208392 3647

Head of Psychology

Dr Diane Bray
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk
Tel: 020 8392 3627

Appendix XIII: Participant Debrief Letter (Study4)

University of Roehampton London

Participant ID number:

ETHICS BOARD

PARTICIPANT DEBRIEF LETTER

Title of Research Project: Knowledge of youth mental health in Romania

Thank you very much for taking part in this study, we greatly appreciate your contribution.

This study was conducted to examine your knowledge about common mental health problems in adolescents, its treatment and preventative strategies, and its possible cause.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw from the study, contact us with your participant number (above) and your information will be deleted from our files. Please be aware, however, that data in summary form may already have been used for publication at the time of request.

If you are troubled or worried about any aspects of the study, or issues it may have raised, please feel free to contact any of the following agencies:

a) Spitalul de Psihiatrie Socola

   Tel: 032 430 920/ 032 224 687

   E-mail: spital@socolaiasi.ro

b) Transmed Expert (private clinic)

   Tel: 0232 293 293

   Email: office@transmedexpert.ro

Should you have a concern about any aspect of your participation in this study, please raise this with me. Alternatively, you may like to take up your concerns with the Head of the Department of Psychology or my Director of Studies.

Investigator:

Alina Dafinoiu
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: dafinoia@roehampton.ac.uk

Director of Studies

Professor Cecilia Essau
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
London SW15 4JD
Email: C.Essau@roehampton.ac.uk

Tel: 0208392 3647

Head of Psychology

Dr Diane Bray
Department of Psychology
Whitelands College
Roehampton University
Holybourne Avenue
SW15 4JD
Email: d.bray@roehampton.ac.uk

Tel: 020 8392 3627

Appendix XIV.1: Vignette 1 (Study4)

University of Roehampton London

Participant ID number:
Participant ID number:

Ion is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. Ion doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.

1. What, if anything, do you think is wrong with Ion?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like Ion, would you ask him to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask him to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother
☐ Would seek help from father
☐ Would seek help from priest
☐ Would seek help from other person (specify): _____
☐ Would seek help from service (specify): _____
☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident
☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop Ion from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about him ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐ Thinking that nothing can help

☐ Concern about what other people might think of him seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify) _____

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help Ion with his problem. Please rate whether the following would be *helpful, harmful or neither* for Ion's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to his problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to him firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for him to see a GP	☐	☐	☐	☐	☐
5. Make an appointment for him to see a psychotherapist	☐	☐	☐	☐	☐
6. Make an appointment for him to see a bioenergy-therapist	☐	☐	☐	☐	☐
7. Ask him whether he is feeling suicidal	☐	☐	☐	☐	☐
8. Suggest he have a few drinks to forget his troubles	☐	☐	☐	☐	☐
9. Rally friends to cheer him up	☐	☐	☐	☐	☐
10. Ignore him until he gets over it	☐	☐	☐	☐	☐
11. Keep him busy to keep his mind off problems	☐	☐	☐	☐	☐
12. Encourage him to become more physically active	☐	☐	☐	☐	☐
13. Other things a friend or family member could do - Please specify: _____	☐	☐	☐	☐	☐

There are a number of different people who could possibly help Ion with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to Ion's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐

3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counselling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A bioenergy-therapist	☐	☐	☐	☐	☐
7. Priest	☐	☐	☐	☐	☐
8. Ericksonian therapist	☐	☐	☐	☐	☐
9. Gestalt therapist	☐	☐	☐	☐	☐
10. Somatic therapist	☐	☐	☐	☐	☐
11. Transactional analyst (AT)	☐	☐	☐	☐	☐
12. Cognitive behavioural therapist (CBT)	☐	☐	☐	☐	☐
13. Experiential therapist	☐	☐	☐	☐	☐
14. A psychiatrist	☐	☐	☐	☐	☐
15. Mother/father	☐	☐	☐	☐	☐
16. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
17. A close family member	☐	☐	☐	☐	☐
18. A close friend	☐	☐	☐	☐	☐
19. Dealing with his problems on his own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐
5. Going regular to church	☐	☐	☐	☐	☐
6. Getting acupuncture	☐	☐	☐	☐	☐

7. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
8. Receiving counselling	☐	☐	☐	☐	☐
9. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
10. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
11. Reading a self-help book on his problem	☐	☐	☐	☐	☐
12. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
13. Going to a local mental health service	☐	☐	☐	☐	☐
14. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
15. Using alcohol to relax	☐	☐	☐	☐	☐
16. Smoking cigarettes to relax	☐	☐	☐	☐	☐
17. Using marijuana to relax	☐	☐	☐	☐	☐
18. Cutting down on use of alcohol	☐	☐	☐	☐	☐
19. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
20. Cutting down on marijuana	☐	☐	☐	☐	☐
21. Dropping school	☐	☐	☐	☐	☐

The next few questions are about things Ion might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like Ion's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with a school-psychologist	☐	☐	☐	☐	☐
5. Keeping regular contact with family	☐	☐	☐	☐	☐
6. Having his both parents at home	☐	☐	☐	☐	☐
7. Avoiding sugary foods	☐	☐	☐	☐	☐
8. Not using marijuana	☐	☐	☐	☐	☐
9. Never drinking alcohol in excess	☐	☐	☐	☐	☐
10. Making regular time for relaxing activities	☐	☐	☐	☐	☐
11. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about Ion's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Ion's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Ion is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
Ion will be for the rest of his life a person who has serious problems.	☐	☐	☐	☐	☐	☐
It is best to avoid Ion so that you don't develop this problem yourself.	☐	☐	☐	☐	☐	☐
Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like Ion's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that Ion will have this problem for the rest of his life.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid Ion so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
Most people would not tell anyone if they had a problem like Ion's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with Ion. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with Ion on the weekend?	☐	☐	☐	☐	☐
To work on a project with Ion?	☐	☐	☐	☐	☐
To invite Ion around to your house?	☐	☐	☐	☐	☐
To go to Ion's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with Ion?	☐	☐	☐	☐	☐

How likely is Ion's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
His own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way he was raised	☐	☐	☐	☐
His parent migration (mother/father)	☐	☐	☐	☐
His both parents migration	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
A curse	☐	☐	☐	☐
The school schedule is too hard	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐
Other causes please specify: _____ __	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

Do you believe that Ion might suffer due to his parent migration (mother/father)?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state ?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

Do you believe that Ion might suffer due to his both parents migration?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3

21	I felt that life was meaningless	0 1 2 3

Sociodemographic

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: _____

4. Marital status: □ Single □ Married / Living with a partner
□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School
□ College/University □ Postgraduate studies (Masters)
□ Postgraduate studies (PhD) □ I did not go to school
□ Other (please specify)_____

6. Place of birth
□ Rural □ Urban

7. How would you describe your ethnic origin? _____

8. Your occupation _____

9. Do you work with adolescents? If yes, in what capacity? _____

Health Knowledge Schedule

Instructions: For each of statements 1– 6 below, respond by **ticking one box only**. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

Mental Health Knowled

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. Most people with mental health problems want to have paid employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help.						
3. Medication can be an effective treatment for people with mental health problems.						
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5. People with severe mental health problems can fully recover.						
6. Most people with mental health problems go to a healthcare professional to get help.						

Instructions: For items 7-12, say whether you think each condition is a type of mental illness by **ticking one box only**.

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
7. Depression						
8. Stress						
9. Schizophrenia						
10. Bipolar disorder (manic depression)						
11. Drug addiction						
12. Grief						

Appendix XIV.2: Vignette 2 (Study4)

University of Roehampton London

Participant ID number:
Participant ID number:

Ion is 17 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. Joe doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-today tasks seem too much for him. This has come to the attention of his teacher, who is concerned about Joe's school achievement. Ion feels he will never be happy again and believes his family would be better off without him. Ion has been so desperate, he is thinking of ways to end his life.

1. What, if anything, do you think is wrong with Ion?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like Ion, would you ask him to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask him to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother
☐ Would seek help from father
☐ Would seek help from priest
☐ Would seek help from other person (specify): _____
☐ Would seek help from service (specify): _____
☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident
☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop Ion from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about him ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐ Thinking that nothing can help

☐ Concern about what other people might think of him seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify) _____

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help Ion with his problem. Please rate whether the following would be *helpful, harmful or neither* for Ion's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to his problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to him firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for him to see a GP	☐	☐	☐	☐	☐
5. Make an appointment for him to see a psychotherapist	☐	☐	☐	☐	☐
6. Make an appointment for him to see a bioenergy-therapist	☐	☐	☐	☐	☐
7. Ask him whether he is feeling suicidal	☐	☐	☐	☐	☐
8. Suggest he have a few drinks to forget his troubles	☐	☐	☐	☐	☐
9. Rally friends to cheer him up	☐	☐	☐	☐	☐
10. Ignore him until he gets over it	☐	☐	☐	☐	☐
11. Keep him busy to keep his mind off problems	☐	☐	☐	☐	☐
12. Encourage him to become more physically active	☐	☐	☐	☐	☐
13. Other things a friend or family member could do - Please specify: _____	☐	☐	☐	☐	☐

There are a number of different people who could possibly help Ion with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to Ion's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐

3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counselling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A bioenergy-therapist	☐	☐	☐	☐	☐
7. Priest	☐	☐	☐	☐	☐
8. Ericksonian therapist	☐	☐	☐	☐	☐
9. Gestalt therapist	☐	☐	☐	☐	☐
10. Somatic therapist	☐	☐	☐	☐	☐
11. Transactional analyst (AT)	☐	☐	☐	☐	☐
12. Cognitive behavioural therapist (CBT)	☐	☐	☐	☐	☐
13. Experiential therapist	☐	☐	☐	☐	☐
14. A psychiatrist	☐	☐	☐	☐	☐
15. Mother/father	☐	☐	☐	☐	☐
16. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
17. A close family member	☐	☐	☐	☐	☐
18. A close friend	☐	☐	☐	☐	☐
19. Dealing with his problems on his own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐
5. Going regular to church	☐	☐	☐	☐	☐
6. Getting acupuncture	☐	☐	☐	☐	☐

7. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
8. Receiving counselling	☐	☐	☐	☐	☐
9. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
10. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
11. Reading a self-help book on his problem	☐	☐	☐	☐	☐
12. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
13. Going to a local mental health service	☐	☐	☐	☐	☐
14. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
15. Using alcohol to relax	☐	☐	☐	☐	☐
16. Smoking cigarettes to relax	☐	☐	☐	☐	☐
17. Using marijuana to relax	☐	☐	☐	☐	☐
18. Cutting down on use of alcohol	☐	☐	☐	☐	☐
19. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
20. Cutting down on marijuana	☐	☐	☐	☐	☐
21. Dropping school	☐	☐	☐	☐	☐

The next few questions are about things Ion might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like Ion's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with a school-psychologist	☐	☐	☐	☐	☐
5. Keeping regular contact with family	☐	☐	☐	☐	☐
6. Having his both parents at home	☐	☐	☐	☐	☐
7. Avoiding sugary foods	☐	☐	☐	☐	☐
8. Not using marijuana	☐	☐	☐	☐	☐
9. Never drinking alcohol in excess	☐	☐	☐	☐	☐
10. Making regular time for relaxing activities	☐	☐	☐	☐	☐
11. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about Ion's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Ion's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Ion is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
Ion will be for the rest of his life a person who has serious problems.	☐	☐	☐	☐	☐	☐
It is best to avoid Ion so that you don't develop this problem yourself.	☐	☐	☐	☐	☐	☐
Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like Ion's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that Ion will have this problem for the rest of his life.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid Ion so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
Most people would not tell anyone if they had a problem like Ion's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with Ion. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with Ion on the weekend?	☐	☐	☐	☐	☐
To work on a project with Ion?	☐	☐	☐	☐	☐
To invite Ion around to your house?	☐	☐	☐	☐	☐
To go to Ion's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with Ion?	☐	☐	☐	☐	☐

How likely is Ion's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
His own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way he was raised	☐	☐	☐	☐
His parent migration (mother/father)	☐	☐	☐	☐
His both parents migration	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
A curse	☐	☐	☐	☐
The school schedule is too hard	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐
Other causes please specify: _____ __	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

Do you believe that Ion might suffer due to his parent migration (mother/father)?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state ?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

Do you believe that Ion might suffer due to his both parents migration?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance us

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Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Sociodemographic

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: _____

4. Marital status: □ Single □ Married / Living with a partner
□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School
□ College/University □ Postgraduate studies (Masters)
□ Postgraduate studies (PhD) □ I did not go to school
□ Other (please specify)_____

6. Place of birth

□ Rural □ Urban

7. How would you describe your ethnic origin? _____

8. Your occupation _____

9. Do you work with adolescents? If yes, in what capacity? _____

Health Knowledge Schedule

Instructions: For each of statements 1– 6 below, respond by **ticking one box only**. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

Mental Health Knowled

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. Most people with mental health problems want to have paid employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help.						
3. Medication can be an effective treatment for people with mental health problems.						
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5. People with severe mental health problems can fully recover.						
6. Most people with mental health problems go to a healthcare professional to get help.						

Instructions: For items 7-12, say whether you think each condition is a type of mental illness by **ticking one box only**.

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
7. Depression						
8. Stress						
9. Schizophrenia						
10. Bipolar disorder (manic depression)						
11. Drug addiction						
12. Grief						

Appendix XIV.3: Vignette 3 (Study4)

University of Roehampton London

Participant ID number:
Participant ID number:

Ion is a 15-year-old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. Ion doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. Ion has been drinking a lot of alcohol over the last year, and recently lost his weekend job because of his hangovers. His parents and friends are very concerned about him.

1. What, if anything, do you think is wrong with Ion?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like Ion, would you ask him to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask him to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother
☐ Would seek help from father
☐ Would seek help from priest
☐ Would seek help from other person (specify): _____
☐ Would seek help from service (specify): _____
☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident
☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop Ion from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about him ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐ Thinking that nothing can help

☐ Concern about what other people might think of him seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify) _____

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help Ion with his problem. Please rate whether the following would be *helpful, harmful or neither* for Ion's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to his problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to him firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for him to see a GP	☐	☐	☐	☐	☐
5. Make an appointment for him to see a psychotherapist	☐	☐	☐	☐	☐
6. Make an appointment for him to see a bioenergy-therapist	☐	☐	☐	☐	☐
7. Ask him whether he is feeling suicidal	☐	☐	☐	☐	☐
8. Suggest he have a few drinks to forget his troubles	☐	☐	☐	☐	☐
9. Rally friends to cheer him up	☐	☐	☐	☐	☐
10. Ignore him until he gets over it	☐	☐	☐	☐	☐
11. Keep him busy to keep his mind off problems	☐	☐	☐	☐	☐
12. Encourage him to become more physically active	☐	☐	☐	☐	☐
13. Other things a friend or family member could do - Please specify: _____	☐	☐	☐	☐	☐

There are a number of different people who could possibly help Ion with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to Ion's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐

3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counselling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A bioenergy-therapist	☐	☐	☐	☐	☐
7. Priest	☐	☐	☐	☐	☐
8. Ericksonian therapist	☐	☐	☐	☐	☐
9. Gestalt therapist	☐	☐	☐	☐	☐
10. Somatic therapist	☐	☐	☐	☐	☐
11. Transactional analyst (AT)	☐	☐	☐	☐	☐
12. Cognitive behavioural therapist (CBT)	☐	☐	☐	☐	☐
13. Experiential therapist	☐	☐	☐	☐	☐
14. A psychiatrist	☐	☐	☐	☐	☐
15. Mother/father	☐	☐	☐	☐	☐
16. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
17. A close family member	☐	☐	☐	☐	☐
18. A close friend	☐	☐	☐	☐	☐
19. Dealing with his problems on his own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for Ion's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐
5. Going regular to church	☐	☐	☐	☐	☐
6. Getting acupuncture	☐	☐	☐	☐	☐

7. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
8. Receiving counselling	☐	☐	☐	☐	☐
9. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
10. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
11. Reading a self-help book on his problem	☐	☐	☐	☐	☐
12. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
13. Going to a local mental health service	☐	☐	☐	☐	☐
14. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
15. Using alcohol to relax	☐	☐	☐	☐	☐
16. Smoking cigarettes to relax	☐	☐	☐	☐	☐
17. Using marijuana to relax	☐	☐	☐	☐	☐
18. Cutting down on use of alcohol	☐	☐	☐	☐	☐
19. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
20. Cutting down on marijuana	☐	☐	☐	☐	☐
21. Dropping school	☐	☐	☐	☐	☐

The next few questions are about things Ion might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like Ion's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with a school-psychologist	☐	☐	☐	☐	☐
5. Keeping regular contact with family	☐	☐	☐	☐	☐
6. Having his both parents at home	☐	☐	☐	☐	☐
7. Avoiding sugary foods	☐	☐	☐	☐	☐
8. Not using marijuana	☐	☐	☐	☐	☐
9. Never drinking alcohol in excess	☐	☐	☐	☐	☐
10. Making regular time for relaxing activities	☐	☐	☐	☐	☐
11. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about Ion's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Ion's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Ion is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
Ion will be for the rest of his life a person who has serious problems.	☐	☐	☐	☐	☐	☐
It is best to avoid Ion so that you don't develop this problem yourself.	☐	☐	☐	☐	☐	☐
Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like Ion's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that Ion could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that Ion is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that Ion will have this problem for the rest of his life.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid Ion so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐
Most people believe that Ion's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
Most people would not tell anyone if they had a problem like Ion's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with Ion. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with Ion on the weekend?	☐	☐	☐	☐	☐
To work on a project with Ion?	☐	☐	☐	☐	☐
To invite Ion around to your house?	☐	☐	☐	☐	☐
To go to Ion's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with Ion?	☐	☐	☐	☐	☐

How likely is Ion's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
His own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way he was raised	☐	☐	☐	☐
His parent migration (mother/father)	☐	☐	☐	☐
His both parents migration	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
A curse	☐	☐	☐	☐
The school schedule is too hard	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐
Other causes please specify: _____ __	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to Ion's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

Do you believe that Ion might suffer due to his parent migration (mother/father)?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state ?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

Do you believe that Ion might suffer due to his both parents migration?

□ Yes □ No

→ If YES:

- how much do you believe Ion is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Ion's state?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Sociodemographic

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: _____

4. Marital status: □ Single □ Married / Living with a partner
□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School
□ College/University □ Postgraduate studies (Masters)
□ Postgraduate studies (PhD) □ I did not go to school
□ Other (please specify)_____

6. Place of birth

□ Rural □ Urban

7. How would you describe your ethnic origin? _____

8. Your occupation _____

9. Do you work with adolescents? If yes, in what capacity? _____

Health Knowledge Schedule

Instructions: For each of statements 1– 6 below, respond by **ticking one box only**. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

Mental Health Knowledge

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. Most people with mental health problems want to have paid employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help.						
3. Medication can be an effective treatment for people with mental health problems.						
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5. People with severe mental health problems can fully recover.						
6. Most people with mental health problems go to a healthcare professional to get help.						

Appendix XIV.4: Vignette 4 (Study4)

University of Roehampton London

Participant ID number:
Participant ID number:

Maria is a 15-year-old living at home with her parents. Since starting her new school last year she has become even more shy than usual and has made only one friend. She would really like to make more friends but is scared that she'll do or say something embarrassing when she's around others. Although Maria's work is OK she rarely says a word in class and becomes incredibly nervous, trembles, blushes and seems like she might vomit if she has to answer a question or speak in front of the class. At home, Maria is quite talkative with her family, but becomes quiet if anyone he doesn't know well comes over. She never answers the phone and she refuses to attend social gatherings. She knows her fears are unreasonable but he can't seem to control them and this really upsets her.

1. What, if anything, do you think is wrong with Maria?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like Maria, would you ask her to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask her to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother
☐ Would seek help from father
☐ Would seek help from priest
☐ Would seek help from other person (specify): _____
☐ Would seek help from service (specify): _____
☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident

☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop Maria from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about him ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐ Thinking that nothing can help

☐ Concern about what other people might think of him seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify) _____

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help Maria with his problem. Please rate whether the following would be *helpful, harmful or neither* for Maria's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to her problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to her firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for her to see a GP	☐	☐	☐	☐	☐
5. Make an appointment for her to see a psychotherapist	☐	☐	☐	☐	☐
6. Make an appointment for her to see a bioenergy-therapist	☐	☐	☐	☐	☐
7. Ask her whether she is feeling suicidal	☐	☐	☐	☐	☐
8. Suggest he have a few drinks to forget her troubles	☐	☐	☐	☐	☐
9. Rally friends to cheer her up	☐	☐	☐	☐	☐
10. Ignore her until he gets over it	☐	☐	☐	☐	☐
11. Keep her busy to keep her mind off problems	☐	☐	☐	☐	☐
12. Encourage her to become more physically active	☐	☐	☐	☐	☐
13. Other things a friend or family member could do - Please specify: _____	☐	☐	☐	☐	☐

There are a number of different people who could possibly help Maria with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to Maria's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't*

					know
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐
3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counselling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A bioenergy-therapist	☐	☐	☐	☐	☐
7. Priest	☐	☐	☐	☐	☐
8. Ericksonian therapist	☐	☐	☐	☐	☐
9. Gestalt therapist	☐	☐	☐	☐	☐
10. Somatic therapist	☐	☐	☐	☐	☐
11. Transactional analyst (AT)	☐	☐	☐	☐	☐
12. Cognitive behavioural therapist (CBT)	☐	☐	☐	☐	☐
13. Experiential therapist	☐	☐	☐	☐	☐
14. A psychiatrist	☐	☐	☐	☐	☐
15. Mother/father	☐	☐	☐	☐	☐
16. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
17. A close family member	☐	☐	☐	☐	☐
18. A close friend	☐	☐	☐	☐	☐
19. Dealing with her problems on her own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for Maria's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for Maria's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐

5. Going regular to church	☐	☐	☐	☐	☐
6. Getting acupuncture	☐	☐	☐	☐	☐
7. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
8. Receiving counselling	☐	☐	☐	☐	☐
9. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
10. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
11. Reading a self-help book on his problem	☐	☐	☐	☐	☐
12. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
13. Going to a local mental health service	☐	☐	☐	☐	☐
14. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
15. Using alcohol to relax	☐	☐	☐	☐	☐
16. Smoking cigarettes to relax	☐	☐	☐	☐	☐
17. Using marijuana to relax	☐	☐	☐	☐	☐
18. Cutting down on use of alcohol	☐	☐	☐	☐	☐
19. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
20. Cutting down on marijuana	☐	☐	☐	☐	☐
21. Dropping school	☐	☐	☐	☐	☐

The next few questions are about things Maria might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like Maria's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with a school-psychologist	☐	☐	☐	☐	☐
5. Keeping regular contact with family	☐	☐	☐	☐	☐
6. Having his both parents at home	☐	☐	☐	☐	☐
7. Avoiding sugary foods	☐	☐	☐	☐	☐
8. Not using marijuana	☐	☐	☐	☐	☐
9. Never drinking alcohol in excess	☐	☐	☐	☐	☐

10. Making regular time for relaxing activities	☐	☐	☐	☐	☐
11. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about Maria's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Maria could snap out of it if she wanted.	☐	☐	☐	☐	☐	☐
Maria's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Maria's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Maria is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
Maria will be for the rest of her life a person who has serious problems.	☐	☐	☐	☐	☐	☐
It is best to avoid Maria so that you don't develop this problem yourself.	☐	☐	☐	☐	☐	☐
Maria's problem makes her unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like Maria's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that Maria could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that Maria is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that Maria will have this problem for the rest of her life.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid Maria so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's problem makes her unpredictable.	☐	☐	☐	☐	☐	☐

Most people would not tell anyone if they had a problem like Maria's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with Maria. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with Maria on the weekend?	☐	☐	☐	☐	☐
To work on a project with Maria?	☐	☐	☐	☐	☐
To invite Maria around to your house?	☐	☐	☐	☐	☐
To go to Maria's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with Maria?	☐	☐	☐	☐	☐

How likely is Maria's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
Her own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way she was raised	☐	☐	☐	☐
Her parent migration (mother/father)	☐	☐	☐	☐
Her both parents migration	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
A curse	☐	☐	☐	☐
The school schedule is too hard	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐
Other causes please specify: _____ __	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to Maria's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to Maria's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

Do you believe that Maria might suffer due to her parent migration (mother/father)?

□ Yes □ No

→ If YES:
- how much do you believe Maria is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Maria's state ?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

Do you believe that Maria might suffer due to his both parents migration?

□ Yes □ No

→ If YES:
- how much do you believe Maria is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Mar's state?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Sociodemographic

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: _____

4. Marital status: □ Single □ Married / Living with a partner
□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School
□ College/University □ Postgraduate studies (Masters)
□ Postgraduate studies (PhD) □ I did not go to school
□ Other (please specify)_____

6. Place of birth

□ Rural □ Urban

7. How would you describe your ethnic origin? _____

8. Your occupation _____

9. Do you work with adolescents? If yes, in what capacity? _____

Health Knowledge Schedule

Instructions: For each of statements 1– 6 below, respond by **ticking one box only**. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

Mental Health Knowled

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. Most people with mental health problems want to have paid employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help.						
3. Medication can be an effective treatment for people with mental health problems.						
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5. People with severe mental health problems can fully recover.						
6. Most people with mental health problems go to a healthcare professional to get help.						

Instructions: For items 7-12, say whether you think each condition is a type of mental illness by **ticking one box only**.

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
7. Depression						
8. Stress						
9. Schizophrenia						
10. Bipolar disorder (manic depression)						
11. Drug addiction						
12. Grief						

Appendix XIV.5: Vignette 5 (Study4)

University of Roehampton London

Participant ID number:

Maria is 16 years old and she is often worried. She worries a great deal about her school performance, her parent's well-being, and her relationships with peers. In addition, she worries about a variety of minor matters such as getting to school on time, what clothes to wear, and getting along with her friends. It takes Maria longer than necessary to accomplish tasks because she worries about making decisions. Maria has trouble sleeping at night and finds that she is exhausted during the day and irritable with her family.

1. What, if anything, do you think is wrong with Maria?

_____

_____

1a. How many adolescents with the same condition have you seen in the last…….
12 months:_____
2 years: _____
3 years: _____

2. If you know an adolescent with the same problem like Maria, would you ask her to go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you ask her to go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother
☐ Would seek help from father
☐ Would seek help from priest
☐ Would seek help from other person (specify): _____
☐ Would seek help from service (specify): _____
☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident
☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop Maria from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about him ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐ Thinking that nothing can help

☐ Concern about what other people might think of him seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify) _____

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help Maria with his problem. Please rate whether the following would be *helpful, harmful or neither* for Maria's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to her problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to her firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for her to see a GP	☐	☐	☐	☐	☐
5. Make an appointment for her to see a psychotherapist	☐	☐	☐	☐	☐
6. Make an appointment for her to see a bioenergy-therapist	☐	☐	☐	☐	☐
7. Ask her whether she is feeling suicidal	☐	☐	☐	☐	☐
8. Suggest he have a few drinks to forget her troubles	☐	☐	☐	☐	☐
9. Rally friends to cheer her up	☐	☐	☐	☐	☐
10. Ignore her until he gets over it	☐	☐	☐	☐	☐
11. Keep her busy to keep her mind off problems	☐	☐	☐	☐	☐
12. Encourage her to become more physically active	☐	☐	☐	☐	☐
13. Other things a friend or family member could do - Please specify: _____	☐	☐	☐	☐	☐

There are a number of different people who could possibly help Maria with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to Maria's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐

3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counselling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A bioenergy-therapist	☐	☐	☐	☐	☐
7. Priest	☐	☐	☐	☐	☐
8. Ericksonian therapist	☐	☐	☐	☐	☐
9. Gestalt therapist	☐	☐	☐	☐	☐
10. Somatic therapist	☐	☐	☐	☐	☐
11. Transactional analyst (AT)	☐	☐	☐	☐	☐
12. Cognitive behavioural therapist (CBT)	☐	☐	☐	☐	☐
13. Experiential therapist	☐	☐	☐	☐	☐
14. A psychiatrist	☐	☐	☐	☐	☐
15. Mother/father	☐	☐	☐	☐	☐
16. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
17. A close family member	☐	☐	☐	☐	☐
18. A close friend	☐	☐	☐	☐	☐
19. Dealing with her problems on her own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for Maria's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for Maria's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐
5. Going regular to church	☐	☐	☐	☐	☐
6. Getting acupuncture	☐	☐	☐	☐	☐

7. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
8. Receiving counselling	☐	☐	☐	☐	☐
9. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
10. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
11. Reading a self-help book on his problem	☐	☐	☐	☐	☐
12. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
13. Going to a local mental health service	☐	☐	☐	☐	☐
14. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
15. Using alcohol to relax	☐	☐	☐	☐	☐
16. Smoking cigarettes to relax	☐	☐	☐	☐	☐
17. Using marijuana to relax	☐	☐	☐	☐	☐
18. Cutting down on use of alcohol	☐	☐	☐	☐	☐
19. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
20. Cutting down on marijuana	☐	☐	☐	☐	☐
21. Dropping school	☐	☐	☐	☐	☐

The next few questions are about things Maria might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like Maria's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with a school-psychologist	☐	☐	☐	☐	☐
5. Keeping regular contact with family	☐	☐	☐	☐	☐
6. Having his both parents at home	☐	☐	☐	☐	☐
7. Avoiding sugary foods	☐	☐	☐	☐	☐
8. Not using marijuana	☐	☐	☐	☐	☐
9. Never drinking alcohol in excess	☐	☐	☐	☐	☐
10. Making regular time for relaxing activities	☐	☐	☐	☐	☐
11. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about Maria's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Maria could snap out of it if she wanted.	☐	☐	☐	☐	☐	☐
Maria's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Maria's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Maria is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
Maria will be for the rest of her life a person who has serious problems.	☐	☐	☐	☐	☐	☐
It is best to avoid Maria so that you don't develop this problem yourself.	☐	☐	☐	☐	☐	☐
Maria's problem makes her unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like Maria's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that Maria could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that Maria is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that Maria will have this problem for the rest of her life.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid Maria so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐
Most people believe that Maria's problem makes her unpredictable.	☐	☐	☐	☐	☐	☐
Most people would not tell anyone if they had a problem like Maria's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with Maria. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with Maria on the weekend?	☐	☐	☐	☐	☐
To work on a project with Maria?	☐	☐	☐	☐	☐
To invite Maria around to your house?	☐	☐	☐	☐	☐
To go to Maria's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with Maria?	☐	☐	☐	☐	☐

How likely is Maria's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
Her own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way she was raised	☐	☐	☐	☐
Her parent migration (mother/father)	☐	☐	☐	☐
Her both parents migration	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
A curse	☐	☐	☐	☐
The school schedule is too hard	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐
Other causes please specify: _____ __	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to Maria's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to Maria's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

Do you believe that Maria might suffer due to her parent migration (mother/father)?

□ Yes □ No

→ If YES:

- how much do you believe Maria is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Maria's state ?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

Do you believe that Maria might suffer due to his both parents migration?

□ Yes □ No

→ If YES:

- how much do you believe Maria is affected by this?

☐ A lot ☐ Less ☐ Not at all

☐ Not sure/Don't know

- which from the following describes Mar's state?

☐ Depression

☐ Anxiety

☐ Behavioural problems

☐ Substance use

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Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Sociodemographic

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: _____

4. Marital status: □ Single □ Married / Living with a partner
□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School
□ College/University □ Postgraduate studies (Masters)
□ Postgraduate studies (PhD) □ I did not go to school
□ Other (please specify)_____

6. Place of birth

□ Rural □ Urban

7. How would you describe your ethnic origin? _____

8. Your occupation _____

9. Do you work with adolescents? If yes, in what capacity? _____

Health Knowledge Schedule

Instructions: For each of statements 1– 6 below, respond by **ticking one box only**. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

Mental Health Knowled

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. Most people with mental health problems want to have paid employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help.						
3. Medication can be an effective treatment for people with mental health problems.						
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5. People with severe mental health problems can fully recover.						
6. Most people with mental health problems go to a healthcare professional to get help.						

Instructions: For items 7-12, say whether you think each condition is a type of mental illness by **ticking one box only**.

	Agree Strongly	Agree Slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
7. Depression						
8. Stress						
9. Schizophrenia						
10. Bipolar disorder (manic depression)						
11. Drug addiction						
12. Grief						

Appendix XV: Analyses (Study4)

Table 9.4 Percentages of respondents mentioning how the person in the vignette could be best helped by a friend or family member

First-aid intentions	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Listen to his/her problem	34 (89.5)	49 (89.1)	47 (87.0)	42 (91.3)	54 (94.7)	226 (90.4)
Talk to him/her firmly	14 (37.8)	28 (53.8)	20 (37.0)	23 (50.0)	27 (47.4)	112 (54.5)
Suggest seeking professional help	30 (78.9)	46 (83.6)	42 (77.8)	34 (73.9)	46 (80.7)	198 (79.2)
Make an appointment with GP	12 (32.4)	19 (34.5)	19 (35.2)	14 (33.3)	13 (22.8)	77 (31.7)
Make an appointment for psychotherapy*	25 (65.8)	33 (60.0)	34 (63.0)	27 (62.8)	40 (71.4)	159 (64.6)
Make an appointment for bioenergy-therapy*	5 (13.2)	4 (7.8)	7 (13.0)	6 (14.3)	7 (13.2)	29 (12.2)
Ask him if he is feeling suicidal	5 (13.2)	10 (18.2)	14 (25.9)	5 (10.9)	7 (12.3)	41 (16.5)
Suggest drinking to forget his/her trouble	0	2 (3.7)	1 (1.9)	0	1 (1.8)	4 (1.6)
Rally friends to cheer him/her up	9 (23.7)	22 (40.7)	21 (38.9)	17 (37.0)	30 (52.6)	99 (39.8)
Ignore him/her until he/she gets over it	1 (2.6)	4 (7.4)	0	3 (6.5)	46 (80.7)	8 (3.2)
Keep him/her busy to mind off the problem	14 (36.8)	25 (45.5)	19 (35.2)	12 (26.1)	19 (33.3)	89 (35.6)
Encourage him/her to be more physically active	27 (71.1)	42 (76.4)	38 (70.4)	27 (58.7)	37 (64.7)	171 (68.4)

* Note: newly added items in this study, as they reflect common source of help in Romania. **Total of all the participants regardless of the vignette received.

Table 9.5 Percentages of respondents mentioning how the person in the vignette could be best helped by naming different people

Type of help mentioned	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
A GP (family doctor)	9 (24.3)	24 (43.6)	19 (35.2)	9 (20.0)	14 (24.6)	75 (30.2)
A teacher	13 (35.1)	24 (43.6)	23 (42.6)	21 (46.7)	28 (49.1)	109 (44.0%)
A counselor	29 (76.3)	44 (80.0)	44 (83.0)	40 (87.0)	44 (77.2)	201 (80.7)
A telephone counselling service	7 (18.9)	11 (20.8)	10 (18.9)	8 (17.8)	8 (14.5)	44 (17.6)
A psychologist	32 (84.2)	52 (94.5)	47 (87.0)	41 (89.1)	51 (89.5)	223 (89.2)
A bioenergy-therapist *	3 (7.9)	6 (10.9)	7 (13.0)	8 (17.4)	11 (19.3)	35 (14.0)
Priest *	14 (36.8)	32 (59.3)	24 (44.4)	19 (41.3)	32 (57.1)	121 (48.4)
Ericksonian therapist *	9 (23.7)	19 (34.5)	19 (35.2)	11 (23.9)	19 (33.3)	77 (30.8)
Gestalt therapist *	6 (15.8)	15 (27.3)	14 (25.9)	7 (15.2)	13 (22.8)	55 (22.0)
Somatic therapist *	8 (21.1)	16 (29.1)	12 (22.2)	9 (19.6)	16 (28.1)	61 (24.4)
Transactional analyst (AT) *	9 (23.7)	10 (18.5)	12 (22.2)	9 (20.0)	17 (29.8)	57 (23.0)
Cognitive behavioral therapist *	23 (60.5)	27 (49.1)	27 (50.0)	23 (50.0)	30 (52.6)	130 (52.0)
Experiential therapist *	14 (36.8)	18 (32.7)	20 (37.0)	16 (34.8)	23 (41.1)	91 (36.5)
A psychiatrist	19 (50.0)	33 (60.0)	31 (57.4)	17 (37.8)	22 (40.0)	122 (49.4)
Mother/father *	28 (73.7)	47 (87.0)	37 (68.5)	29 (63.0)	45 (80.4)	186 (75.0)
Other mental health professional	11 (28.9)	21 (38.9)	20 (37.0)	21 (45.7)	21 (37.5)	94 (37.9)
A close family member	19 (50.0)	42 (76.4)	36 (66.7)	30 (65.2)	37 (66.1)	164 (65.9)
A close friend	23 (62.2)	41 (74.5)	39 (72.2)	31 (67.4)	38 (69.1)	172 (69.6)
Dealing with his own problems	2 (5.4)	3 (5.5)	3 (5.6)	4 (8.7)	(5.5)	15 (6.1)

*Note: newly added items in this study, as they reflect common source of help in Romania. ** Total of all the participants regardless of the vignette received.

Table 9.6 Percentages of respondents mentioning different medicines as 'helpful' for the person's problem described in the vignette

Type of medicine	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Vitamins	21 (55.3)	32 (58.2)	28 (51.9)	22 (47.8)	36 (63.2)	139 (55.6)
St. John's wort	5 (13.2)	11 (20.4)	10 (18.9)	12 (26.1)	18 (32.1)	56 (22.7)
Antidepressants	13 (34.2)	21 (38.2)	24 (44.4)	9 (19.6)	9 (15.8)	76 (30.4)
Tranquilizers	0	1 (1.9)	1 (1.9)	1 (2.2)	1 (1.8)	4 (2.0)
Antipsychotic	2 (5.3)	2 (3.7)	5 (9.4)	2 (4.3)	3 (5.3)	14 (4.0)
Sleeping pills	4 (10.5)	12 (21.8)	5 (9.4)	2 (4.3)	8 (14.0)	31 (12.4)

** Note: total of all the participants regardless of the vignette received.

Table 9.7 Percentages of respondents naming different activities as 'helpful' for the person described in the vignette

Type of activities	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Becoming more physically active	31 (81.6)	46 (83.6)	42 (77.8)	31 (67.4)	43 (75.4)	193 (77.2)
Getting relaxed training	21 (55.3)	30 (54.5)	30 (56.6)	29 (63.0)	39 (68.4)	149 (59.6)
Practising meditation	10 (26.3)	16 (29.6)	23 (43.4)	15 (32.6)	16 (28.1)	80 (32.0)
Having regular massage	6 (15.8)	17 (30.9)	16 (29.6)	13 (28.3)	19 (33.3)	71 (28.4)
Going regularly to church *	10 (26.3)	30 (54.5)	21 (38.9)	18 (39.1)	25 (43.9)	104 (41.6)
Getting acupuncture	3 (7.9)	7 (12.7)	9 (16.7)	5 (10.9)	8 (14.0)	32 (12.8)
Getting up for the sunlight	12 (32.4)	23 (41.8)	24 (44.4)	14 (30.4)	19 (33.3)	92 (36.9)
Receiving counselling	35 (92.1)	52 (94.5)	49 (90.7)	41 (89.1)	50 (87.7)	227 (90.8)
Receiving CBT *	24 (63.2)	41 (75.9)	36 (66.7)	29 (64.4)	33 (57.9)	163 (65.7)
Searching the problem on a website	7 (18.4)	18 (32.7)	13 (24.1)	11 (23.9)	11 (19.3)	60 (24.0)
Reading a self-help book	8 (21.1)	25 (45.5)	21 (38.9)	22 (47.8)	17 (30.4)	93 (37.3)
Joining a support group	33 (86.8)	49 (89.1)	46 (85.2)	37 (80.4)	41 (71.9)	206 (82.4)
Going to local mental health services	14 (36.4)	26 (47.3)	25 (46.3)	13 (28.3)	23 (40.4)	101 (40.4)

Being admitted to a psychiatric ward of a hospital	4 (10.5)	7 (12.7)	6 (11.1)	4 (8.7)	4 (7.0)	25 (10.0)
Using alcohol to relax	0	2 (3.6)	2 (3.7)	3 (6.5)	1 (1.8)	8 (3.2)
Smoking cigarettes to relax	0	3 (5.5)	2 (3.7)	0	1 (1.8)	6 (2.4)
Using marijuana to relax	0	2 (3.6)	3 (5.6)	2 (4.3)	2 (3.5)	9 (3.6)
Cutting down on use of alcohol	34 (89.5)	45 (81.8)	39 (73.6)	35 (76.1)	43 (75.4)	196 (67.2)
Cutting down on smoking cigarettes	29 (76.1)	39 (70.9)	30 (55.6)	28 (60.9)	42 (73.7)	168 (67.2)
Cutting down on marijuana	33 (86.8)	43 (79.6)	42 (77.8)	37 (80.4)	49 (86.0)	204 (81.9)
Dropping out of school	1 (2.6)	4 (7.3)	4 (7.4)	0	4 (7.0)	13 (5.2)

*Note: newly added items in this study, as they reflect common source of help in Romania. **Total of all the participants regardless of the vignette received

Table 9.8 Percentages of respondents mentioning different preventive activities as 'helpful' for the person described in the vignette

Types of activities	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Keeping physically active	33 (86.8)	49 (89.1)	42 (77.8)	34 (73.9)	50 (87.7)	208 (83.2)
Avoiding stressful situations	26 (68.4)	34 (61.8)	32 (59.3)	24 (52.2)	35 (61.4)	151 (60.4)
Keeping regular contact with friends	29 (76.3)	42 (76.4)	49 (90.7)	35 (76.1)	50 (87.7)	205 (82.0)
Keeping regular contact with family *	35 (92.1)	54 (98.2)	50 (92.6)	43 (93.5)	55 (96.5)	237 (94.8)
Having both his parents at home *	34 (8.5)	45 (81.8)	44 (81.5)	36 (78.3)	52 (91.2)	211 (84.4)
Contact with school psychologist *	32 (84.2)	45 (81.8)	42 (77.8)	39 (84.8)	48 (84.2)	206 (82.4)
Avoiding sugary foods	5 (13.2)	6 (11.1)	7 (13.0)	7 (15.2)	8 (14.3)	33 (13.3)
Not using marijuana	31 (81.6)	47 (85.5)	43 (79.6)	38 (82.6)	47 (82.5)	206 (82.4)
Never drink alcohol in excess	31 (81.6)	47 (87.0)	46 (85.2)	40 (87.0)	48 (84.2)	212 (85.1)
Regular time for relaxing activities	35 (92.1)	52 (94.5)	52 (96.3)	42 (91.3)	52 (91.2)	233 (93.6)
Having a religious or spiritual belief	22 (57.9)	38 (70.4)	32 (59.3)	24 (52.2)	33 (57.9)	149 (59.8)
Taking yoga courses *	10 (27.8)	12 (23.1)	15 (28.8)	13 (28.3)	14 (25.0)	64 (26.4)
Discussing problems on Facebook *	3 (8.3)	6 (11.5)	5 (9.6)	4 (8.7)	7 (12.5)	25 (10.3)

*Note: newly added items in this study, as they reflect common source of help in Romania. **Total of all the participants regardless of the vignette received.

Table 9.9 Percentages of respondents mentioning each category to describe personal stigma towards the person described in the vignette

Stigmatizing attitudes	Depression	Depression and alcohol consumption	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Snap out of it if she/he wanted	12 (31.6)	27 (49.1)	21 (38.9)	14 (30.4)	17 (29.8)	103 (41.4)
Problem is a sign of personal weakness	9 (23.7)	19 (34.5)	12 (22.2)	10 (22.2)	14 (24.6)	71 (28.5)
Problem is not a real medical illness	9 (23.7)	15 (27.8)	14 (25.9)	15 (32.6)	19 (33.3)	91 (36.5)
She/he is' dangerous to others'	3 (7.9)	6 (11.1)	2 (3.7)	4 (8.9)	2 (3.6)	21 (8.5)
Has serious problems for the rest of his/her life*	2 (5.4)	1 (1.8)	2 (3.7)	3 (6.5)	1 (1.8)	13 (5.2)
Avoid him/her not to develop the same problem	0	1 (1.8)	0	1 (2.2)	2 (3.5)	7 (2.8)
This problem makes him/her unpredictable	16 (42.1)	26 (47.3)	21 (38.9)	13 (28.3)	13 (22.8)	94 (37.6)
You would not tell anyone if you had similar problems like him/her	2 (5.3)	4 (7.4)	3 (5.6)	2 (4.4)	3 (5.4)	19 (7.7)

*Note: newly added items in this study, as they reflect common personal stigma attitudes in Romania. Results indicate if participants *agree or strongly agree* with stigmatizing attitudes towards the person described in the vignette. ** Total of all the participants regardless of the vignette received.

Table 9.10 Percentages of respondents mentioning each category to describe how other people would agree or strongly agree with stigmatizing attitudes towards the person described in the vignette (public stigma)

Stigmatizing attitudes	Depression	Depression and alcohol	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
Most other people believe he/she could snap out of it if he/she wanted	18 (47.4)	34 (61.8)	29 (53.7)	22 (47.8)	23 (40.4)	143 (57.2)
Most people believe that his/her problem is a sign of personal weakness	20 (52.6)	32 (58.2)	25 (46.3)	24 (52.2)	23 (40.4)	141 (56.4)
Most people believe his/her problem is not a real medical illness	15 (39.5)	26 (48.1)	18 (33.3)	20 (43.5)	28 (49.1)	129 (51.8)
Most people believe that she/he is dangerous	15 (39.5)	13 (24.1)	11 (20.4)	9 (19.6)	10 (10.5)	51 (20.5)
Most people believe that she/he will have this problem for the rest of her/his life *	9 (23.7)	12 (22.2)	13 (24.1)	12 (26.1)	7 (12.3)	57 (22.9)
Most people believe that it is the best to avoid him/her so you do not develop the same problem	8 (21.1)	11 (20.0)	11 (20.4)	10 (21.7)	6 (10.5)	50 (20.0)
Most people believe that his/her problem makes him/her unpredictable	18 (47.4)	27 (50.0)	28 (51.9)	16 (34.8)	21 (36.8)	115 (46.2)
Most people would not tell anyone ifthey had a similar problem like him/her	11 (28.9)	20 (36.4)	30 (55.6)	19 (41.3)	22 (38.6)	115 (46.0)

*Note: newly added items in this study, as they reflect common public stigma attitudes in Romania. **Total of all the participants regardless of the vignette received.

Table 9.11 Percentages of respondents mentioning each category to describe how they would feel about spending time with the person described in the vignette

Stigmatizing attitudes	Depression	Depression and alcohol	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
To go out with Ion/Maria at the weekend	9 (33.3)	11 (30.6)	8 (18.6)	13 (38.2)	21 (56.8)	69 (43.5)
To work on a project with Ion/Maria	10 (37.0)	14 (38.9)	10 (23.3)	14 (41.2)	25 (67.6)	79 (44.6)
To invite Ion/Maria around to your house	7 (25.9)	12 (33.3)	8 (18.6)	14 (41.2)	16 (43.2)	57 (32.2)
To go to Ion's/Maria's house	7 (25.9)	14 (28.9)	9 (20.9)	16 (47.1)	20 (54.1)	66 (27.2)
Would you be happy to develop a close relationship with Ion/Maria?	5 (19.2)	9 (25.0)	11 (25.6)	13 (40.6)	16 (45.7)	54 (31.4)

** Note: total of all the participants regardless of the vignette received. Results indicate if participants would *definitely* feel right to spend time the person described in the vignette

Table 9.12 Percentages of respondents rating cause of mental disorder described in the vignette as "very like" or "somewhat likely "

Causes of depression	Depression	Depression and alcohol	Depression and suicide ideation	Social phobia	Generalized anxiety	Total ** (%)
His/her own bad character	7 (18.4)	9 (17.0)	8 (15.1)	3 (10.9)	1 (2.7)	42 (23.7)

A brain disease	10 (26.3)	14 (26.4)	11 (20.8)	29 (63.0)	5 (13.5)	44 (23.7)
The way he/she was raised	23 (60.5)	36 (67.9)	37 (68.5)	43 (93.5)	24 (64.9)	104 (59.1)
His/her parent migration (mother/father)*	36 (94.8)	53 (96.4)	53 (98.1)	44 (84.8)	36 (97.3)	165 (92.2)
Staying at home alone because his/her parents are working abroad*	35 (92.1)	52 (96.3)	52 (96.3)	41 (89.1)	35 (94.6)	170 (96.1)
Having to take care of his/her younger siblings because his parent are abroad *	32 (84.1)	48 (88.9)	46 (85.1)	26 (34.8)	34 (91.9)	155 (87.6)
His /her both parents migrated *	31 (81.6)	39 (89.1)	48 (88.9)	12 (26.6)	36 (97.3)	172 (97.2)
Stress	14 (37.8)	33 (61.1)	27 (50.0)	11 (32.4)	13 (35.1)	65 (36.7)
A genetic or inherited problem	5 (13.1)	8 (14.5)	7 (13.0)	4 (11.8)	5 (13.5)	22 (12.6)
God's will	2 (5.2)	3 (5.6)	5 (9.3)	5 (14.7)	3 (8.1)	11 (6.3)
Bad luck	14 (37.8)	7 (13.0)	8 (15.1)	5 (14.7)	3 (8.1)	7 (4.0)
A curse *	16 (42.1)	29 (53.7)	21 (38.9)	25 (73.5)	27 (73.0)	118 (67.4)
The school schedule is too busy *	21 (56.7)	32 (59.2)	25 (46.3)	26 (76.5)	27 (73.0)	123 (70.3)
Too many exams and homework at school*	22 (59.4)	30 (59.3)	37 (68.6)	18 (52.9)	25 (37.8)	104 (59.1)
The normal ups-and-downs of life	17 (44.7)	30 (58.8)	33 (64.7)	17 (50.0)	14 (37.8)	93 (52.5)
A mental illness	24 (64.8)	30 (58.8)	36 (69.3)	25 (73.5)	32 (86.5)	45 (25.4)
Being teased by his/her peers at school because his/her parents are working abroad *	30 (81.0)	46 (90.2)	42 (80.8)	27 (79.4)	33 (89.2)	49 (27.7)
Having to stay with his/her relatives because the parents are abroad *	23 (62.2)	31 (59.6)	35 (67.3)	13 (38.2)	15 (40.5)	82 (46.6)
A physical illness	27 (72.9)	36 (70.6)	39 (75.0)	29 (85.3)	27 (73.0)	138 (78.4)
Other causes	18 (69.3)	35 (92.1)	36 (83.7)	20 (84.0)	5 (23.8)	50 (41.7)

*Note: newly added items in this study, as they reflect common public stigma attitudes in Romania. **Total of all the participants regardless of the vignette received.

Table 9.13 Percentages of respondents mentioning how the person in the vignette could be best helped by a friend or family member

First-aid intentions	Professionals	Non-Professionals
Listen to his/her problem	118 (89.4)	108 (91.5)
Talk to him/her firmly	52 (40.3)	60 (51.3)
Suggest seeking professional help	108 (81.8)	90 (76.3)
Make an appointment with GP	46 (36.5)	31 (26.5)
Make an appointment for psychotherapy*	89 (69.5)	70 (59.3)
Make an appointment for bioenergy-therapy*	15 (12.5)	14 (12.0)
Ask him/her if he/she is feeling suicidal	17 (13.0)	24 (20.3)
Suggest drinking to forget his/her trouble	3 (2.3)	1 (.9)
Rally friends to cheer him/her up	52 (39.4)	47 (40.2)
Ignore him/her until he/she gets over it	2 (1.5)	6 (5.1)
Keep him/her busy to mind off the problem	36 (27.3)	53 (44.9)
Encourage him/her to be more physically active	80 (60.6)	91 (77.1)

Note: Professionals consist of social worker, psychologist, Senco, psycho-pedagogy. Non-Professionals consist of teachers and parents

Table 9.14 Percentages of respondents mentioning how the person in the vignette could be best helped by a friend or family member

Type of help mentioned	Professionals	Non-professionals
A GP (family doctor)	45 (34.4)	30 (25.6)
A teacher	46 (35.1)	63 (53.8)
A counsellor	110 (83.3)	91 (77.8)
A telephone counselling service	25 (19.5)	19 (16.5)
A psychologist	116 (87.9)	107 (90.7)
A bioenergy-therapist *	19 (14.4)	16 (13.6)
Priest *	58 (44.6)	63 (53.4)
Ericksonian therapist *	55 (41.7)	22 (18.6)
Gestalt therapist *	41 (31.1)	14 (11.9)
Somatic therapist *	46 (32.6)	15 (12.7)
Transactional analyst (AT) *	43 (32.6)	14 (12.1)
Cognitive behavioral therapist *	88 (66.7)	42 (35.6)
Experiential therapist *	63 (50.8)	28 (23.7)
A psychiatrist	66 (50.8)	56 (47.9)
Mother/father *	97 (74.0)	89 (76.1)
Other mental health professional	51 ((38.9)	43 (36.8)

A close family member	78 (59.5)	86 (72.9)
A close friend	81 (62.8)	91 (77.1)
Dealing with his/her own problems	10 (7.8)	5 (4.2)

Note: Professionals consist of social worker, psychologist, Senco, psycho-pedagogy experts.

Non-Professionals consist of teachers and parents

Table 9.15 Percentages of respondents mentioning different medicines as 'helpful' for the person's problem described in the vignette

Type of medicine	Professionals	Non-Professionals
Vitamins	72 (54.5)	67 (56.8)
St. John's wort	29 (22.3)	27 (23.1)
Antidepressants	43 (32.6)	33 (28.0)
Tranquilizers	2 (1.5)	3 (2.5)
Antipsychotic	3 (2.3)	7 (5.9)
Sleeping pills	17 (13.0)	14 (11.9)

Table 9.16 Percentages of respondents naming different activities as 'helpful' for the person described in the vignette

Type of activities	Professionals	Non-Professionals
Becoming more physically active	99 (75.0)	94 (79.7)
Getting relaxed training	77 (58.8)	72 (61.0)
Practising meditation	40 (30.5)	40 (34.2)
Having regular massage	34 (25.8)	37 (31.4)
Going regular to church *	45 (34.1)	59 (50.0)
Getting acupuncture	15 (31.1)	17 (14.4)
Getting up for the sunlight	41 (31.1)	51 (43.6)
Receiving counselling	124 (93.9)	103 (87.3)
Receiving CBT *	94 (71.8)	69 (59.0)
Searching the problem on a website	30 (22.7)	30 (25.4)
Reading a self-help book	46 (34.8)	47 (40.2)
Joining a support group	116 (87.9)	90 (76.3)
Going to local mental health services	67 (50.8)	34 (28.8)

Being admitted to a psychiatric ward of a hospital	17 (12.9)	8 (6.8)
Using alcohol to relax	3 (2.3)	5 (4.2)
Smoking cigarettes to relax	2 (1.5)	4 (3.4)
Using marijuana to relax	2 (1.5)	7 (5.9)
Cutting down on use of alcohol	104 (78.8)	92 (78.6)
Cutting down on smoking cigarettes	85 (64.4)	83 (70.3)
Cutting down on marijuana	111 (84.7)	93 (78.8)
Dropping out of school	4 (3.0)	9 (7.6)

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